September, 1956

Canadian Hospital

- *Menus for a month*
- *Dietary cost control*
- *Cheese for every taste*
- *R.J.H. overcomes dining problems*
- *Meal service at ranch-style hospital*
- *Food Service at Lethbridge Municipal*
- *Certification of administrators*

Canadian Hospital Association

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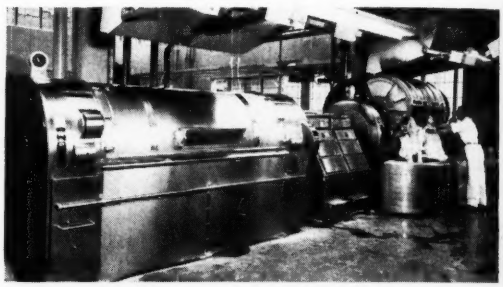

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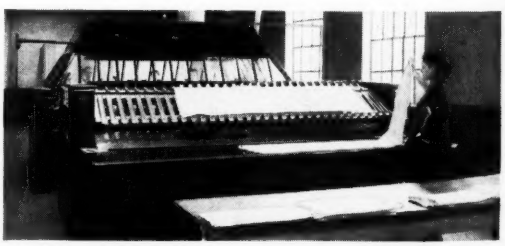

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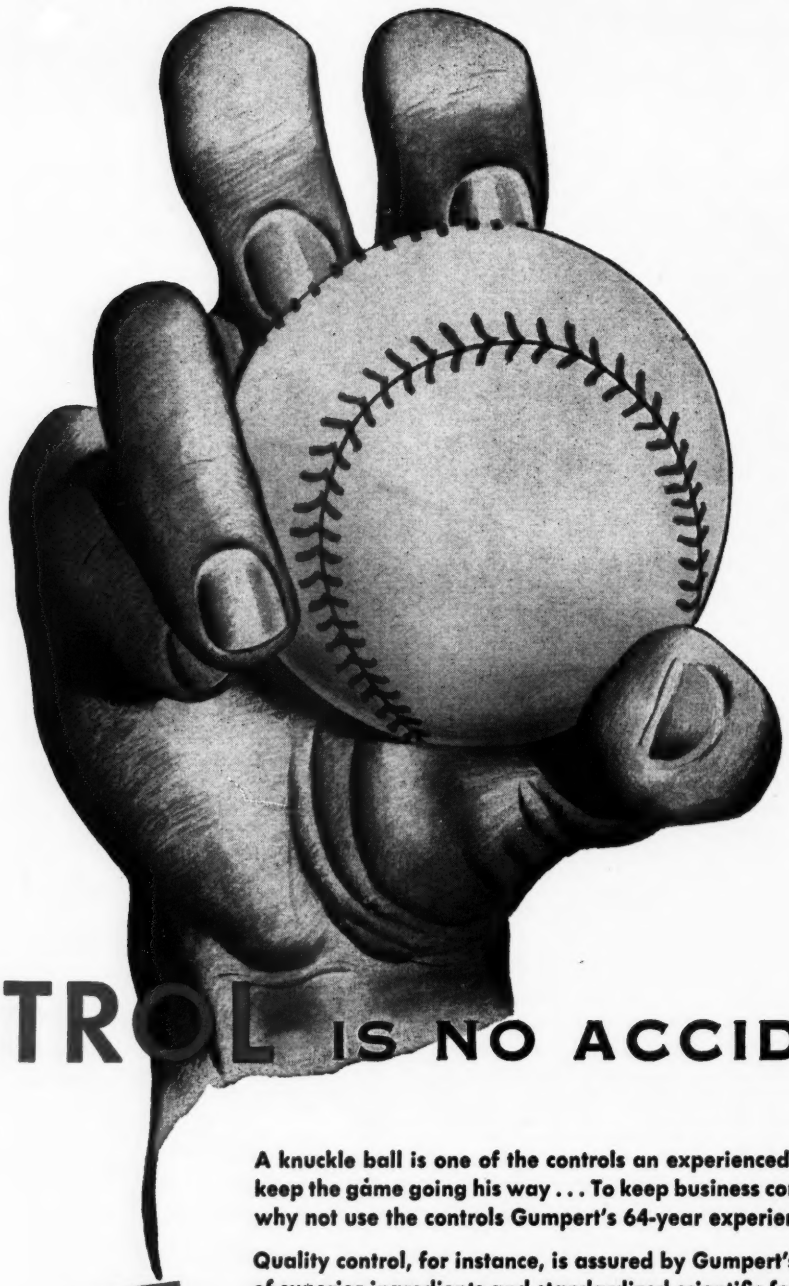

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Notes About People

L. R. Adshead, Secretary Treasurer, Associated Hospitals of Alberta

(This is the third in a series of biographical notes, introducing secretaries of provincial hospital associations.)

L. R. Adshead has been secretary treasurer of the Associated Hospitals of Alberta since 1947. Born and educated in Edmonton, he entered the hospital field in 1928, when he joined the staff of the University of Alberta Hospital, in that city. From 1929 to 1943, he remained on the hospital's staff as accountant, being promoted then to treasurer and executive assistant to the superintendent. In 1952, he was appointed to his present position as business administrator of the hospital.

L. R. Adshead

In addition to holding the office of secretary treasurer of the provincial hospital association, Mr. Adshead was chairman of the economics committee during 1946 and 1947. A member of the original committee which organized the Alberta Blue Cross Plan in 1948, he is currently on the plan's board of trustees. From 1948 to 1950, he served as a member of the Alberta Health Survey Committee which was established by the provincial government of Alberta (with funds provided under the National Health Program) to survey health services in the province. He is a trustee on the board of governors of the Archer Memorial Hospital, Lamont, Alberta, and is also a member of the American College of Hospital Administrators.

Mr. Adshead has the rather unusual distinction of being able to look at the hospital field from three different viewpoints — as business administrator of a hospital, as secretary of a provincial hospital association, and as a trustee on a hospital board. It is not often that one working in the hospital field has opportunities to learn from such varied experience, simultaneously. Undoubtedly, this is one of the reasons which gives Reg. Adshead such broad understanding of hospital matters and why his counsel and guidance is sought so frequently by hospital administrators and others throughout the Province of Alberta.

Although by nature conservative in his approach to problems, Reg. is imaginative and progressive in his attitudes, bringing forth and developing many new ideas. Industrious as well as ingenious, he has a tremendous capacity for work and accomplishment. His friendly manner, fine sense of humour, and ability to meet people and put them at ease, has made for him many friends and admirers.

Community affairs are not put aside either, despite a busy work schedule. As a member of the Edmonton Rotary Club, Reg. has been active on several committees. — *W.D.P.*

• • • •

John Smith Leaves Yorkton

John Smith, superintendent of the Yorkton General Hospital, Yorkton, Sask., for the past fifteen years, has been honoured at several recent functions on the occasion of his retirement from active hospital administration. The gifts bestowed on Mr. Smith included an inscribed silver tray from the board of governors of the hospital, testifying to his loyal service as their chief executive officer. Notable among the social functions was a banquet tendered in his honour by the officers of the Saskatchewan Hospital Association.

Mr. Smith came to Canada from the U.K., early in this century. After years of hard work as a farmer, he strove, as a government administrator, to restore the prosperity of the rural municipality of Insinger during the depression years. Later, he travelled extensively throughout the province, helping to establish and maintain the good relations that have always existed between the Saskatchewan Anti-tuberculosis League and the municipalities. He played an active part in the Saskatchewan Hospital Association, in which he was the first recipient of a life membership, having served for many years as secretary-treasurer, and for two years as president. Mr. Smith was a member of the advisory committee of the Health Services Planning Commission of Saskatchewan.

In the national field, he served as one of Saskatchewan's delegates to the Assembly of the Canadian Hospital Association and as a member of that association's board of directors.

Although Mr. Smith will reside with his family in Vancouver, the hospital authorities and his many Yorkton friends are grateful that he will be retained in an advisory capacity for consultations on future developments. His periodic visits to Saskatchewan will be welcomed by his host of acquaintances and will mean frequent renewals of the many warm friendships which John Smith has made in the hospital field.

• • • •

New Chief Dietitian

Patricia Beckwith has been appointed chief dietitian of the Queensway General Hospital, Toronto, Ont. After receiving her basic education in England, Miss Beckwith specialized in household economics at the University of Toronto, graduating with the degree of Bachelor of Arts. She served her internship at the University Hospital, Edmonton, Alta., and has been a member of the dietary staffs of the Archer Memorial Hospital, Lamont, Alta., St. Michael's Hospital and Sunnybrook Hospital, Toronto, Ont. She has just returned to Canada after a year spent

Patricia Beckwith

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People

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in Great Britain studying hospital dietary services.

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New Medical Superintendent of St. Joseph's Hospital, Victoria

Ernest N. Boettcher, B.Sc., M.D., D.H.A., has been appointed medical superintendent of St. Joseph's Hospital, Victoria, B.C., as of Sept. 1, a position formerly held by Dr. A. J. Brunet, of Misericordia Hospital, Edmonton, Alta.

Dr. Boettcher studied medicine at the University of Alberta, and completed the post-graduate course in Hospital Administration at the University of Toronto. After his residency at the Strong Memorial Hospital in Rochester, N.Y., Dr. Boettcher held the position administrative assistant at the Toronto General Hospital.

• • • •

Sister Lachance Leaves Saskatoon

Sister Annette Lachance, s.g.m., supperior and administrator of St. Paul's Hospital, Saskatoon, Sask., from 1953 to 1956 is leaving the city. Sister Lachance had previously held the same appointment from 1947 to 1950. She devoted herself to the re-organization and future expansion of the hospital, which will increase its number of beds to 320. Provincial approval has been given to these plans, which are largely due to her energy and foresight. In addition, it was during this period that the hospital obtained full accreditation from the Joint Commission on Accreditation of Hospitals.

Sister Marie Laforce has been named to succeed Sr. A. Lachance as Superior-Administrator of St. Paul's Hospital. Sister Laforce has served for many years as assistant at Edmonton General Hospital, and is a member of the governing council of that hospital. During her service there, she played an active part in the extension and modernization.

• • • •

Red Army (ex-) at North Bay

Dr. Paul Karnauchow was been appointed pathologist to the North Bay Civic Hospital, and St. Joseph's General Hospital, North Bay, Ont. Three days after graduation from a Soviet medical school, Dr. Karnauchow found himself a captain in the Red Army until his capture by the Germans in 1943. Freed in 1945, he started work as a doctor in the International Refugee Organization Hospital, Regensburg, Germany. Deterred from returning to his homeland by the summary execution dealt out to officers who allowed themselves to be captured, he came to Canada in 1949, entered a hospital as an intern, and sat his examinations again — this time in English. Dr. Karnauchow specialized in pathology in Montreal and Ottawa, and was until recently on the staffs of Ottawa General Hospital and the pathology department of Ottawa University.

• • • •

Visit of British Nurse-Editor

Marion West, of London, England, is deputy editor of *The Nursing Times*, and a leader in the field of industrial nursing in Great Britain. She came to Canada to attend the recently held biennial of the Canadian Nurses' Association. She also visited the Toronto General Hospital to discuss the hospital's recent adoption of a two-year educational program for nurses, followed by a year's internship, which will go into operation with the September class. Miss West graduated in nursing from the Winnipeg General Hospital School of Nursing in 1930 before en-

(Continued on page 22)

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People

(Continued from page 16)

tering the public health field prior to her return to England in 1953.

• • • •

Retirement of Mary S. Byers

Mary S. Byers, obstetrics supervisor since 1927 at Belleville General Hospital, Belleville, Ont., retired recently at an impressive ceremony when she was presented with gifts that included a substantial cheque from the Board of Governors, and a diamond dinner ring presented on behalf of the nursing staff and other bodies. Miss Byers graduated from Kingston General Hospital in 1921, and spent the interim years at the Long Island College and Mount Sinai Hospitals, New York, where she took post graduate courses in obstetrics and paediatrics.

• • • •

Manitoulin Hospital Builder

Dr. Robert W. Davis, retired physician and surgeon, whose death was announced recently, will still be remembered by many residents of Manitoulin Island, Ontario. After graduating in medicine from the University of Toronto in 1910, Dr. Davis set up practice at Mindemoya on Manitoulin Island, where in 1913 he built his own hospital which he ran for 20 years. It was taken over by the Red Cross in 1934.

• • • •

Northwestern General Administrator

R. J. Long, administrator of the North Bay Civic Hospital since 1953, will shortly take up his new appointment as administrator of the Northwestern General Hospital, Toronto, Ont. Mr. Long came to North Bay from Calgary, Alta., where he was for three years administrator of the Alberta Red Cross Crippled Children's Hospital, prior to which he had held appointments at the Hospital for Sick Children, Toronto, and the Toronto General Hospital.

• • • •

Director of Nursing, Victoria

Mary L. Richmond, B.N., M.A., is the newly appointed director of nursing at the Royal Jubilee Hospital, Victoria, B.C. Miss Richmond replaces Lucie Woodrow, and was previously educational director of nurses at the Royal Jubilee Hospital from 1951 to 1955. A graduate in nursing from the Vancouver General Hospital, Miss Richmond is a Bachelor of Nursing from McGill, and obtained her Masters degree from the Teachers' College, Columbia University, New York.

• • • •

New C.P.A. President

Dr. C. H. Pottle, superintendent of the Hospital for Nervous and Mental Diseases, St. John's, Nfld., was elected president of the Canadian Psychiatric Association at its recent meeting in Quebec City.

• • • •

New Superintendent of Recently Completed Hospital

Newly named as superintendent of the Ontario Hospital, North Bay, Ont., Dr. Walter H. Weber will be taking over the management of the hospital immediately it is ready for occupancy late this year. Dr. Weber graduated in medicine from the University of Toronto in 1927 and entered the Ontario mental health service in 1937, since which time he has devoted his entire medical practice to psychiatry. He served in this capacity in the R.C.A.F. during World War II, and

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since 1948 has been assistant superintendent at the Ontario Hospital, Hamilton, Ont.

• • • •

Vancouver General Hospital Medical Staff Appointments

Dr. William St. John Buckler, a graduate in medicine of the University of London, England, takes office as director of physical medicine, and Dr. Philip S. Vassar has been appointed assistant surgical pathologist at the Vancouver General Hospital, Vancouver, B.C. Dr. Lawrence E. Ranta, the hospital's assistant medical director, has been elected chairman of health and welfare planning with the Community Chest.

• • • •

New Nurses' Residence Named

A distinguished Canadian nurse, formerly professor of nursing at the University of Saskatchewan and executive secretary of S.R.N.A., Kathleen Ellis of Penticton, B.C., was honoured recently when the new nurses' residence of University Hospital, Saskatoon, Sask., was officially named "Ellis Hall". Miss Ellis was a graduate of Johns Hopkins Hospital, Baltimore, and from 1942 to 1950 had served as emergency nursing advisor to the Canadian Nurses' Association.

• • • •

Leave of Absence for Therapist

The cerebral palsy clinic at the Royal Jubilee Hospital, Victoria, B.C. will be without a speech therapist for a short period, while Marie Crickmay completes her Masters degree at Kalamazoo, Michigan. Parents and nurses will take over certain vital duties in her absence.

• • • •

Frederick W. Rolph

The death was announced recently of Dr. Frederick W. Rolph. Dr. Rolph graduated in medicine from the University of Toronto before World War I, and practiced in Toronto. He had been on the staff of the Toronto General Hospital from about 1916, and had over a period of years lectured at the university.

• • • •

New Director of Rehabilitative Medicine

Dr. M. T. F. Carpendale was recently appointed director of rehabilitative medicine at the University Hospital, Edmonton, Alta. Dr. Carpendale is a native of the U.K., and has just completed post-graduate study at the Mayo Foundation, Rochester, N.Y.

U.S. Surgeon Finds India's Health Plans Impressive

India's public health plans are sound, with an emphasis on quality rather than quantity, stated Dr. Charles W. Mayo, while visiting Union Minister of Health, Rajkumari Amrit Kaur, and leaders in medicine in Delhi recently. He stated that the few blueprints he had seen and discussed with medical men were impressive and complimented the Indian leaders on their right emphasis on right things. —*Calcutta Medical Journal*

• • • •

U.S. Administrator in Australia

Gerhard Hartman, superintendent of the State University of Iowa Hospitals, acted as consultant for six weeks this summer in the planning of an educational program in hospital administration at Australia's New South Wales University of Technology. His work was sponsored by the W. K. Kellogg Foundation.

Mr. Hartman also served in an advisory capacity to the Australian Hospital Association, the Australian Institute of Hospital Administrators, the University of Sydney's College of Medicine and the Australian government.

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W. Douglas Piercey, M.D., Editor

The Canadian Hospital

Obiter Dicta

Food—a joy and necessity of life

IT IS true that "man does not live by bread alone", yet it is apparent that a sizable proportion of one's life is spent in eating. Food is a common topic of conversation, ranking along with the weather. When man is not eating or thinking about eating, he is spending much of the remaining time doing something which will supply him with his next meal. It has always been thus, for history relates the time-consuming process of early man's struggle to secure sufficient food. Today, in our complex civilization, the number of people who are engaged in growing, processing, preparing and serving food makes up a very large segment of our population indeed.

While the majority of people spend a great deal of time thinking about food, this is particularly true of the average patient. Today, in addition to satisfying the patient's basic need for food, the hospital menu becomes a therapeutic tool. Only in the past few decades have we come to realize that, to gain the maximum therapeutic value from food, skill in cooking has to be supplemented by scientific knowledge of what to cook. This is when the food specialist — the dietitian — entered the picture.

Selecting, preparing, and serving food is the function of the food service department. In numbers of personnel and extent of budget, this department takes second place only to nursing. In our hospitals, both from the administrative and therapeutic aspect, preparing a scientific diet and serving it in an attractive manner calls for specialized knowledge and an efficiently administered department.

Serving good food which will be appreciated by patients poses no small problem. The hospital dietitian must have not only a basic knowledge of various foods, their caloric content, those rich in vitamins and minerals, and those suitable for different clinical categories of patients, but she must know how to purchase food economically. She must have the ability to plan a balanced diet which is tasty — "tasty" meaning, among other things, that hot food will be served *hot*.

To produce maximum results in the department, the dietitian requires many people to assist her. Therefore, much of her time must be spent in educating the staff. Along with a trained staff, adequate facilities are equally necessary. In recent years, great advances have been made in planning the modern hospital kitchen so that its location, layout, and equipment will simplify and speed up the work.

Planning a hospital menu has many complications. It has to be made out well in advance of the actual meal being served and consideration must be given to the season, the availability and price of supplies, and other factors. In this issue, which is largely devoted to food and the food service department, we are publishing sample menus from two hospitals for the month of October. In addition, two special articles are included on staple foods — fish and cheese. We are indebted to all those who prepared these special dietary articles.

The Long-term Patient in the General Hospital

THE STORY of the impetus given to hospital construction in Canada under the federal-provincial hospital construction grants program introduced in 1948, is well known. In less than a decade there has been a phenomenal increase in the number of hospital beds of all categories available to the Canadian people. During this time, many new hospitals have been built and many established institutions have been enlarged. Notwithstanding this tremendous growth in accommodation for patients, many general hospitals continually operate above their peak level of optimum efficiency and, in some institutions, waiting lists for elective cases are still common.

In such hospitals the length of stay becomes of paramount importance. This decade has brought a shortening of the average stay per patient and, today, the national average length of stay in all public general hospitals is

some 10 days. It must be remembered that this average stay of 10 days includes many short-term cases. Comprised in this figure, also, are those patients who stay much longer and, in particular, those over 30 days who are referred to generally as long-term patients. A hospital bed which accommodates a new patient every 10 days will be available for some 36 patients a year, while the same bed, when occupied by long-term patients of 30 days average stay, will accommodate only 12, for the same period. This is a vital consideration for the administrator and medical staff of general hospitals with long waiting lists and it is important to everyone concerned with the cost of acute hospital care.

Today, long-term cases are constituting an increasing proportion of all hospitalized patients and many factors, allied with present-day living, will continue to bring up the percentage. To mention but a few trends in modern-day living, a longer life-span with its related illnesses, inadequate living accommodation in smaller homes and apartments, and the increasing tendency for both husband and wife to be gainfully employed, have all led to the need for care outside the home for long-term patients and their consequent admission to general hospitals.

According to Memorandum No. 10, *Hospitals in Canada*, published by the Research Division, Department of National Health and Welfare, at the end of 1953, the number of hospital beds of all categories in Canada was 11.5 per 1,000 population, and of these 6.2 per 1,000 were general and allied special beds. In Nova Scotia and Saskatchewan, one active treatment bed per 1,000 population was occupied by chronic patients and, in Ontario, roughly 10 per cent of all hospital beds normally available for the acutely ill were similarly occupied.

Many long-stay patients need to be in a general hospital for medical reasons. Others, however, stay in general hospitals for long periods of time merely because it is so difficult to find suitable accommodation for them elsewhere. If one could calculate the amount of time spent by administrators, head nurses, social service workers, members of the medical staff, and others in trying to find such patients other accommodation, it would amount to a surprisingly large number of hours.

The uninitiated may contend that as these patients all came to the hospital from some place, it should be a simple matter to discharge them to their former residences. Those in the hospital field are well aware that this does not necessarily follow. Before being admitted they may have been in a rooming house — and, in the meantime, the room has been rented. Perhaps they were living with a married son or daughter; when the time comes for their discharge reasons are presented, sometimes valid, sometimes not, as to why they cannot return. Some have come from a home for the aged which cares for well people but is not equipped to give even minimal nursing care. The administrator is then informed that they cannot return to their former surroundings. Some can be discharged from hospital needing only follow-up treatment in the out-patient or physiotherapy departments, but there is no one available to transport them to and from clinics.

In Part I of the Guide Issue of *Hospitals*, Journal of the American Hospital Association, published August 1, 1956, will be found a highly informative study of the characteristics of long-term patients in general hospitals. According to a survey conducted in hospitals in the State of Maryland, more than three-fourths of the long-term patients were staying in the hospital for completion of treatment (73 per cent) or completion of diagnostic studies (4 per cent). Nearly one-tenth (9 per cent) remained not because of need for general hospital care, but because a bed was not available in a more suitable place. Similarly, 2 per cent remained because they had no home to go to, and 11 per cent remained for a variety of reasons not related to need for hospital care. Hence, 22 per cent of the long-term patients did not need care in a general hospital at the date of the survey.

Where the patient's medical condition indictates that he should be sent to a long-stay hospital, very often it takes a great deal of time to arrange a transfer. The reason for this delay is not only that we do not have enough long-term beds but that long-term hospitals themselves have the same problem; they, too, have patients who do not need the therapeutic care offered in their institutions but are there simply because other accommodation is not readily available for them. This curtails patient turnover in the long-stay hospital to a negligible figure.

While considerable study is currently being undertaken on the question of the long-term patient in the general hospital, the problem is far from being solved. In many instances, the patient ceases to be primarily a medical and hospital problem and is, in fact, a welfare case. It would appear that what is needed is more homes for the aged or similar institutions which can care for patients requiring minimum supervision. This, in turn, would also allow a somewhat easier flow of chronic patients from the general to the long-stay hospital.

Hôpital—Silence S.V.P.

UN DES plus grands experts en matière hospitalière a noté récemment que l'administration faisait face aujourd'hui à un véritable défi pour l'administration: celui de trouver des moyens adéquats pour réduire le bruit à l'intérieure de l'hôpital. On pourrait facilement avoir l'impression du dehors que l'hôpital est un endroit extrêmement tranquille. Sur des rues avoisinantes, nombreuses enseignes indiquent que l'on est à proximité d'un hôpital. Et chauffeurs et piétons sont avisés de garder le silence. De tels avis font penser au non-initié que, dans l'hôpital, tout le monde marchent sur la pointe des pieds et parlent bas pour que les patients, chacun d'eux très malade, aient le repos et la tranquillité complète qui leur assureront un avantage thérapeutique maximum.

De l'intérieur, pourtant, la situation peut sembler toute différente; et parfois, si l'on installait dans le corridor de l'hôpital un instrument pour mesurer le bruit l'on constaterait que le bruit est plus fort à l'intérieur qu'à l'extérieur, et que le corridor est souvent aussi congestionné que la rue. En plus d'un personnel très varié l'on est étonné par la diversité d'inventions mécaniques que l'on peut voir dans le corridor d'un hôpital moyen.

Le volume de bruit dans un hôpital est, parfois, accentué par des erreurs de construction, résultant de défauts dans le plan, ou par un entretien inférieur du bâtiment. Tout ce qui est nécessaire, quelquefois, c'est d'utiliser un outil tout à fait simple mais efficace — la burette à huile que l'on trouve dans chaque ménage. Chaque maîtresse de maison connaît sa valeur et en garde une à la maison, et pourtant, dans la majorité des hôpitaux, elle est rarement vue — sauf dans l'usine génératrice d'électricité.

Tâchons à voir à ce que les hôpitaux que l'on projète en ce moment, et ceux de l'avenir, tiendront compte dans leur construction, de tous les moyens possibles de réduire le bruit. On peut le réduire beaucoup en accordant l'attention requise aux planchers, aux murs, plafonds, portes, et grilles. Ce dont nous avons surtout besoin, c'est une campagne active parmi tous les membres du personnel, pour les rendre conscients du bruit. Avec leur appui, tout hôpital peut devenir un endroit tranquille au profit des patients et du personnel.

Dietary Cost Control

Walter W. B. Dick, C.A.,
Moncton, N.B.

IN current conversation and literature pertaining to hospitals, the word *cost* appears only less frequently than the word *patient*. This is significant. Everyone supports the objective of the hospital — the welfare of the patient. However, no matter how noble our philosophy of hospital care may be, the extent of patient care provided is restricted by the cost involved. It is evident, therefore, that it is only common sense to make the economic resources assignable to hospital affairs provide as many satisfactions as man's ingenuity can invent.

Hospital management is duty bound, therefore, to seek the maximum return for each hospital dollar spent in terms of benefits provided for the patient. The basic requirement for economy is a principle in hospital administration invoking the need for *cost control* in all phases of the institution's operation, the dietary no less than other services.

On the other hand, the dietary service is an important factor in patient therapy. The food prepared must not only have high nutritional qualities and be well balanced dietetically, but it must look appetizing and be satisfying in order to contribute to the contentment of both patients and personnel. Thus the *quality* factor of the food service must *not* be sacrificed in a proper desire to economize.

Nature of Control

When contemplating control, accounting is recognized as a major administrative tool because it is based on accurate and adequate knowledge of a situation. While accounting is not the only management device necessary for assuring economy in hospital operation, the other devices alone cannot succeed to the same extent as they do with the assistance of accounting. With the two-fold, and in some respects conflicting, objectives of quality and economy in the dietary service, there arises the necessity of coordinating the specialized knowledge of the accountant and the dietitian.

The accounting system must be in accord with the objectives of the hospital and should not conflict with the administrative or functional plan of organization. Thus the accountant should understand the function of the dietary service, what results it is expected to achieve, and the organizational pattern and procedures adopted to attain these objectives. The accountant should appreciate the role of the dietary personnel in planning diets, menus, and recipes; in purchasing food and equipment; in preparing and serving food; in recruiting, training and supervising personnel; and last, but not least, in keeping essential records.

As head of the dietary service, the dietitian is responsible to the administrator for the performance of her department. As well as being very important in several other ways, the dietary service is economically significant in that it will spend at least 15 cents out of each dollar of direct hospital expense and will employ in the neighbourhood of 15 per cent of the total personnel of the hospital. Since the results achieved must be measured largely in terms of general and financial statistics, it is imperative that the dietitian be familiar with accounting records and procedures. This does not imply a need for technical accounting skill but it does require acceptance, understanding, and appreciation of the usefulness of accounting techniques. The successful combination and co-ordination of these abilities can bring about the type of control designed to minimize waste and stimulate efficiency while, at the same time, safeguarding quality and service.

Basic Accounting Records

In order to provide a basis for national uniformity in hospital accounting, the *Canadian Hospital Accounting Manual* recommends certain logical general ledger accounts for the accumulation of direct dietary expense. In addition to gross salaries and wages, accounts are provided for food and other dietary expenses. It should be mentioned that considerable refinement can be made in these accounts depending upon the desire of the individual hospital for various types of information. The chart of accounts proposed in CHAM may be expanded or reduced and is adaptable to the large as well as the small hospital. In the case of large hospitals, and for that matter in many small hospitals as well, the accounts listed are expanded by further subdivisions of the expense accounts.

Walter Dick

It is often difficult to distinguish one hospital department from another when there is overlapping of services. An illustration of this, in respect to the dietary department, would be the distribution of patients' meals by nursing or housekeeping personnel. It will be noted, however, that CHAM recommends the principle of *departmental* accounting in so far as the general ledger is concerned. Therefore, the general ledger accounts for the dietary service will include only *direct* expenses and exclude *overhead* and other types of *indirect* expense incurred by the dietary service, but more logically accumulated as charges in other departments. Thus the complete cost of the dietary service is not reflected in the expense accounts maintained in the general ledger.

Basic Accounting Control

Nevertheless, the accounting information, in respect to dietary expense, accumulated in the general ledger, is basic to determining dietary costs. It provides the basis for establishing and maintaining accounting control. The information is particularly valuable when combined with statistical data such as the "served meal", "adult patient day", et cetera.

By calculating the "served meal" cost, the "patient day" cost, et cetera, certain measures of cost (known as unit costs) are developed. These unit costs may be determined from a total of the dietary expense accounts or for each class of expense in the dietary service, *e.g.*, total cost per served meal or raw food cost per served meal. Such unit costs may then be used to make comparisons with those of prior periods or with those of similar institutions.

In Peterborough Civil Hospital, Peterborough, Ont., trays, leaving conveyor belt, are transported upward automatically in a wall shaft.

The differences in the unit costs are sometimes referred to as variances. It is the duty of the accountant to explain the variances which have occurred in the unit costs between one month and another or between institutions. In this connection the first objective is to localize the change or changes in a specific expense item. When this is accomplished the difference is accounted for in terms of quantity used or price, or both. Having knowledge of the cause of the change in unit cost a wise management is able to take the appropriate action called for under the circumstances. Admittedly, these methods will produce very rough unit cost figures but they do permit the analysis of certain variances. Such information, together with an understanding of the shortcomings in the data, may be all that management can utilize effectively.

Much of the usefulness of unit costs (being historical costs) is lost if they are not computed currently. It is preferable to prepare the unit costs monthly, as soon after the completion of the accounting period as possible. The cost trends thus revealed can be studied, and prompt remedial action taken as indicated.

Control of Supplies

It has been said, "Any kind of knowledge gives a certain amount of power. A knowledge of details has served in many a crisis. A knowledge of details has often caught an error before it became a catastrophe". This is a most apt quotation in so far as accounting controls for dietary costs are concerned. Dietary supplies, particularly food, consist of many different items. Food, edible and universally desirable, requires all the physical control, internal check, and accounting control which can be devised.

An adequate inventory record is required. This record should indicate each type of purchase, the quantity ordered, received, and issued; and the balance on hand at any given date. Essential too, as part of the record, or at least as a memo, is the price paid for each shipment received. Such a record may be referred to as a perpetual inventory. The entries to be made in the inventory record will come from other related forms. Such forms are needed for the following items:

Ordered. The purchase is negotiated in the beginning by a purchase order specifying the item wanted together with the price and shipping instructions. It may be preceded in a purchase requisition and by calling tenders.

Received. The supplier's invoice supported by a receiving slip and purchase order, substantiates the in-entry (debit) for the inventory. The receiving slip may be a copy of the purchase order or preferably a form originated on receipt of the merchandise in the receiving room.

Issued. A requisition form authorizing issuance of items from the storeroom to the dietary department provides the information for recording an out-entry (credit) on the perpetual inventory record. This form also is evidence of use and expense. Approval of the dietitian is required on this form, as well as acknowledgment of receipt by the party taking custody of the goods.

On Hand. Orderly inventory records and storeroom procedures are essential for accuracy in determining consumption and stock on hand. A physical inventory should be taken from time to time. This inventory should be checked with the perpetual inventory record. Differences are adjusted by appropriate entries, with the physical inventory used as the correct count.

A perpetual inventory record as suggested here for the dietary department is most suitable for staple items. These items are usually ordered in rather large quantities for consumption over a period of time. Where the hospital orders perishable items (such as meats and fresh vegetables) on a basis of daily requirements, it is probably impractical to use a perpetual inventory record. Information then, with regard to use, is obtained directly from the purchase invoices after deducting any unused supplies on hand, determined by physical count at the end of the accounting period.

Day-to-day Costing

In the remarks about the calculations of the rough unit costs from the general ledger accounts, it was inferred

that such costs, prepared at the end of an accounting period, were rather late for current action. A dietitian, alert to the need for current financial information for the dietary department, may want records showing the cost as recently as yesterday. This type of accounting is useful in cost control and is obtained from records which are not usually part of the general ledger system, However, it should be recognized that any such "uncontrolled" records must be reconcilable with the pertinent general ledger control accounts.

For purposes of day-to-day costing by the dietitian, it is necessary to design forms and establish certain routine procedures for the accumulation of the basic data. For example let us think of a "served meal" as a unit and the "cost of raw food" as the unit cost we want.

First of all we would require a daily meal census. This would take into account lunches, infant formulae, et cetera, on a pre-determined basis, as well as regular meals for patients and staff. The net result would be the total number of "statistical" meals served for the day.

We would then require a record of all food consumed. In its primary form this may require each food item to be listed and priced separately. In its secondary stage, however, the information would be summarized so as to show the value of food by classes (meats, bread, dairy products, et cetera) and in total, which was consumed during the day.

It then becomes a matter of simple arithmetic to calculate the unit cost (average cost of raw food per meal) for the day by dividing the number of meals served into the dollar value. This is done for each class of food and for the total. The percentage of the total represented by each class of food can also be easily calculated.

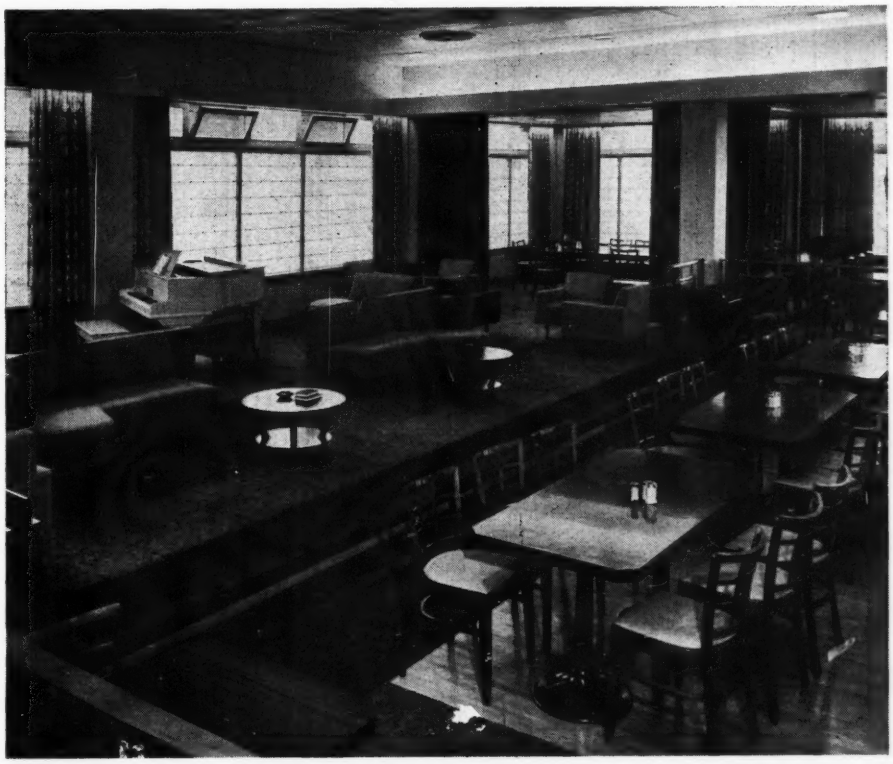
A monthly form may be designed to which the daily figures can be transferred. Thus the same unit cost and percentage figures for the month to date can become available. Similarly, a cumulative record giving the information for the year to date may be maintained.

The information for the record of food consumed may come from a variety of sources such as, daily receiving sheet, requisitions, and other records of purchases and issues. As it is an "uncontrolled" record (not an integral part of the general ledger system), accuracy should be verified each month by checking the total cost of raw food for the month against the account for this item in the dietary expense section of the general ledger. The records briefly described and discussed here yield raw food costs only which usually exceed 50 per cent of the total cost of the dietary department.

In addition, there are other direct costs such as gross salaries and wages, supplies for serving the prepared food, and miscellaneous expense for utensils, cleaning materials, aprons and uniforms, and like items. Since these expenses are kept in the dietary section of the general ledger, monthly accumulative expense of this nature can be derived from these ledger accounts.

Cost Analysis

The services of other departments, such as linen, housekeeping, engineering, et cetera, may be directly utilized for the dietary service but, under the uniform accounting system outlined in CHAM, these expenses are recorded in the general ledger in accounts classified under the appropriate depart-



A glimpse of the lovely north cafeteria of the Toronto Western Hospital, Toronto, Ont., shows the raised lounge and, to the right, a section of one of the mezzanines which becomes a private dining room when the leatherette doors are closed.

ments. In some instances these accounts can be recorded in such a way that they may be analysed to find the expense incurred by the dietary department. The more elaborate the breakdown of general ledger expense accounts, and the greater the number of supplementary financial and statistical records, the more readily such further data will be available.

When the dietary department receives services from other departments, an apportionment of the expense will be required to determine the portion involved in those services. This will almost invariably be the case with general or indirect services such as administration, maintenance of building, operation of physical plant, motor service, and laundry. It would also be necessary for such overhead expenses as depreciation.

Such complete allocation of expense is required in any calculation of total dietary cost. It is a somewhat involved process and is described in some detail in Part III of the *Canadian Hospital Accounting Manual.* Experience indicates that indirect expense, which would be apportioned to the dietary service, may range from 5 per cent to 10 per cent of the total expense of the department. Calculation of total dietary cost is productive of much useful information but in this article we are primarily concerned with the substantial measure of control obtainable without cost analysis.

Food Control

Obviously the desired financial results can only be obtained when the most efficient methods are utilized. Poor financial results point up the short-comings in this direction. In an analysis of the situation, we should be assured that the following conditions referred to as food controls are in effect.

Purchasing

(a) That the last current market prices are used and that tenders are called under the proper conditions.

(b) That buying is done by using standard specifications.

(c) That items purchased are inspected on receipt for quality, weight, size, and count.

(d) That estimates of needs are made daily for perishables and orders placed accordingly.

Storage

(a) That adequate storage space is provided to protect the inventory against pilferage and deterioration.

(b) That orderly storage methods are maintained with the principle of first-in first-out in effect.

(c) That the inventory is periodically examined for slow moving items.

Preparation

(a) That meals are planned in advance using a master menu.

(b) That standard recipes are utilized *at all times.*

(c) That standing orders for replenishing such items as coffee, sugar, milk, butter and bread are *not* in effect but rather that such items are ordered according to requirement.

(d) That portion control is used.

Service

(a) That the service should result in satisfaction to patients as evidenced by periodic examination of returned food.

(b) That the garbage is weighed and examined from time to time to assure that there is not excess waste by returns, over-preparation or careless preparation.

(c) That the dietitian visits patients at meal time routinely for reaction to tray service.

Kitchen Layout and Equipment

In addition to the items included in "Food Control" above, the accountant should be aware of the importance of a well planned work area and routines in the kitchen in effecting control.

Furthermore, the cost and quality of food may be favourably affected by the appropriate use of machines. Therefore, a thorough understanding of the physical aspects of the dietary department is basic to an evaluation of the accounting results.

Accountant and Dietitian

There is a common impression that unit costs are developed with the exactitude of a problem in arithmetic. This is an unfortunate misconception. However, costs can be developed that are useful for evaluating efficiency as well as for other purposes. We should be aware of the positive forces inherent in appropriately applied accounting.

There is no attempt here to prescribe specific record forms, as forms and systems must be developed to suit the particular organization concerned. Appended references to the *Canadian Hospital Accounting Manual* and other publications or articles should be helpful. Nor should we lose sight of the value of consultation with our colleagues in other institutions, attendance at meetings and institutes, and thus keeping abreast of trends and developments.

The accountant familiar with the objectives of the organization, as well as the activities and services carried out, should be able to devise forms and routines so that the accounting and statistical data developed will be reliable and informative. With the cooperation and interest of the dietitian who understands the processes and objectives of accounting, and who accepts and appreciates its usefulness, the results can be analyzed, interpreted, and measured for the administrator. This forms the basis for executive action and control so that maximum efficiency can be achieved.

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A Cheese for Every Taste

Elaine Found*

NOT many Canadians are conscious of the sharply different food habits existing from community to community within their own country. For instance, one might be hard pressed to explain why cheese consumption at a given time was 4.2 pounds per capita in Three Rivers, Que., while at the same time the figure stood at 8.7 pounds in Sudbury, Ontario, and 6.5 pounds per capita in Saskatoon, Sask. Per capita consumption of cheese for all Canada in 1955 was 6.3 pounds.

With the National Cheese Festival in full swing during the month of October it is revealing to look at recent studies of cheese consumption in Canada to see precisely what are some of the changing attitudes toward this high protein food which continues to stand high in the favour of nutritionists and housewives alike.

Not unnaturally, consumption is higher in winter than in summer because colder weather appears to act as a spur to the appetite for cheese. Not so obvious are the reasons for differerences in consumption between language groups hinted at earlier in this article. It has been found that families where the housewife speaks French only use less cheese than those where the housewife speaks English or is bilingual. It has been suggested that the reason for low per capita consumption of cheese where only French is spoken is that there has been less advertising and promotion of the product in French-speaking Canada than in the rest of Canada.

Country of origin and the economic status of Canadian families has a tremendous bearing on their cheese consumption. British families use the most cheddar. East European, Jewish and Syrian families eat three to four times as much cottage cheese as those from Britain or western Europe. It appears to be a general rule that the more money a family has to spend the less it spends on cheddar cheese. To some extent in high income families cheddar gives way to the more expensive, fancy imported cheeses.

Number of children in the family and their ages are strong controls on the amount of cheese consumed in the home. Partially for economic reasons purchases of cheese in a family decline sharply as the size of the family increases. Children eat considerably less cheese than do adults. In fact most nutritionists agree that Canadians do not eat as much cheese as they should to maintain a well-balanced diet and, indeed, this deficiency is generally greater in families with children. There is no evidence to indicate at what age children begin to have preferences for cheese, but it is established that with the increasing age of the individual comes a desire for the stronger, fuller flavours of mature cheddar. Women, by and large, appear to prefer the milder, softer texture of processed cheeses which accounts for the high percentage of processed cheese sales in some urban centres.

Women are pretty well agreed that they want coloured cheese because they think it has a better, more appetizing appearance.

More than forty varieties of cheese are now manufactured or processed in Canada from ten or more domestic and foreign-name types. Almost every year sees new varieties and types being added to the already long list. There's sure to be a cheese to suit every taste!

Canadian cheddar is, of course, the king of them all . . . beloved the world over and prized by tourists. Cheddar is available in the natural form . . . the so-called "white" cheese . . . and the well-known coloured cheddar. To suit individual tastes cheddar is sold as mild, medium and old flavoured. For persons who prefer a very sharp tang, very old cheddar is obtainable. An all-purpose cheese, cheddar is "at home" any place that cheese is used . . . in cooking, on the table, with fruit for dessert, in sandwiches and with crackers, and on cheese trays. There are also a number of wine-cured varieties . . . these have a distinctive flavour with a winey tang, and are used principally for dessert, cheese trays, and for snacks.

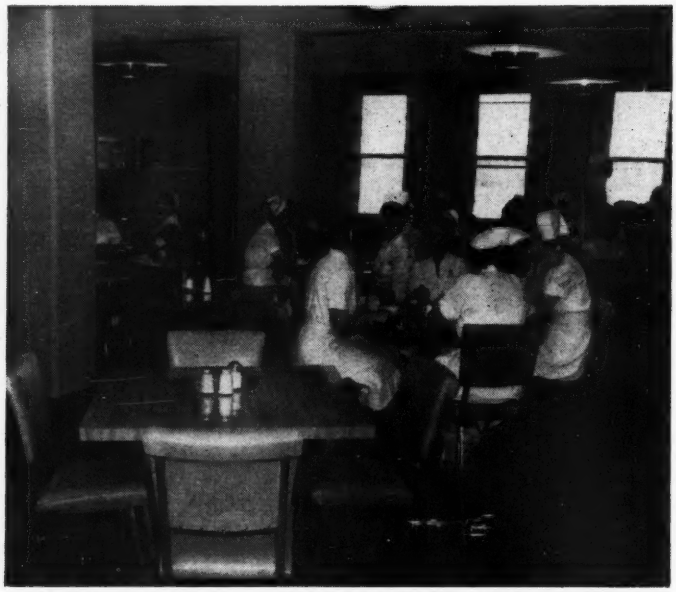
Progress in cheese packaging has brought us the handy individually wrapped portions for snacks in home, hospital and restaurant. It is interesting to note that of all the cheese-producing countries in the world, Canada and Britain are the only ones now making a large percentage of non-pasteurized cheddar, allowing the cheese to age much better. By law,

(*continued on page 124*)

* *The author is Assistant Food Editor of Dairy Foods Service Bureau, a division of Dairy Farmers of Canada.*

An attractive assortment for between-meal snacks: Cheddar cheese slices—milk flavour, fingers of brick, wedges of a sharp cheddar, cream cheese, thin slices of Swiss, a wedge of blue cheese, and a gay scarlet coated edam in the centre of the tray. This is served with some butter-rich wafers, thinly sliced rye bread, and mugs of milk.

Lethbridge Municipal Hospital



Food Service Centralized and Decentralized

Bright pastels on the cafeteria walls are complemented by multi-coloured terrazzo floors.

Dawn Virtue Jones
Chief Dietitian
Lethbridge Municipal Hospital
Lethbridge, Alberta

EVERYONE loves to be associated with something new and the Lethbridge Municipal Hospital, which opened June 3, 1955, is new! To the dietary department of this hospital, the attainment of a smoothly running food service has been a thrill and a challenge, as vital as smoothly running equipment. Particularly is this true of those who have held key positions in cooking and supervision for the past fifteen months.

Let us review our dietary department, which operates as a combination centralized-decentralized service for patients, with a pay cafeteria for staff members. First — the heart of all dietary operations — the main kitchen. This kitchen is planned for easy supervision, which partially explains why the administrative dietitian, whose office is centrally located in this kitchen, is also the kitchen supervisor. The main kitchen is rectangular, with the special-diet kitchen, administrative dietitian's office, formula room, salad room, and short-term storeroom built as separate units on one side of the kitchen. Placement of equipment divides the opposite side of the kitchen proper into the chef's section and the dessert cook's section. In the section occupied by the chef and assistant cook, there is a horizontal four-oven gas stove with cooking top over three ovens and grill over the fourth, with a deep fat frier at one end to complete the unit. There are two stainless steel work tables here, one equipped with a sink, and the other supporting the meat-cutting machine. A third wooden-top table is the chef's area for cutting all carcass meat. Next to the stove unit is a three-compartment steamer and three stock pots in various sizes, all set in a raised, drained section. A sixty-quart mixer and a multi-shelved food warmer complete the chef's department. The chef is responsible for the preparation of all food on the main plate except garnishes. He has an experienced cook as his assistant. The dietary department has a cook on duty twenty-four hours a day, when one includes the night cook as dietary representative at night.

The dessert cook's section houses two work tables, one a stainless steel, binned table and the other a wooden pastry table with a twenty-quart mixer. An electric triple-banked set of ovens is supplied for baking. The dessert cook, with her assistant, is responsible for preparation of all desserts and bread products. The third cook in charge of a work section is the salad cook. She and her helper prepare salad plates, side salads, sandwich plates, sandwiches, and garnishes for the main plate. Since the alternate choice on the menu both in the cafeteria and on the patients' trays is a sandwich and side salad at dinner and a main salad plate at supper, the salad room is a vital part of the food production system. This room is constructed in U shape with cupboards, counters and a sink. One mobile, open cart is used to transport salads and desserts to the ward kitchens. Each cook's section has its own walk-in refrigerator with a seprate deep-freeze used for storage. Although non-perishable supplies are requisitioned from a central storeroom, a small open storeroom is kept in the main kitchen, from which all cooks draw their daily supplies.

Miscellaneous sections in the main kitchen are a standard pot-washing area and a refrigerated walk-in garbage room. The latter not only contributes to greater sanitation, but also enables more careful checking on food loss.

A special-diet kitchen, staffed by a therapeutic dietitian, a cook, nourishment girl, and of course those students taking their dietary training, is representative of the centralized part of our service. This particular kitchen is equipped to handle its own food preparation. It contains a household size stove, preparation table, counters and cupboards, a food blender, as well as a holding oven for the pyrex dishes. An unheated, open-type tray wagon of 33-tray capacity is used for distri-

bution of special-diet trays to patients. A daily average of 105 therapeutic meals are sent out in compact insulated units on heated conveyors. We are now initiating a "selective menu service" for all patients on therapeutic diets. The menu given these patients is the regular diet menu, with some adaptations made by the therapeutic dietitian. This dietitian, with the student nurses in her charge, makes daily rounds to teach patients how to modify the regular diet to their special one. This service aids in the more ready acceptance of therapeutic foods.

Each ward kitchen, one on each of three patient floors, dispensing food for all diets except therapeutic, has a non-professional supervisor and a staff under her according to the patient capacity of the floor on which she serves. She and her staff operate the kitchens from 6:30 a.m. to 9:00 p.m. These kitchens are suitably equipped in stainless steel. The actual equipment consists of a single-tank dishwasher, a seven-gallon coffee urn, water urn, bain-marie, dish-warmer, refrigerated cupboards, sinks and storage cupboards.

The amount of food to be prepared in the main kitchen is taken from a cook's work sheet compiled each day by the administrative dietitian. The amount of different foods to be placed on each patient wagon is taken from a blackboard count brought up to date before each meal by the ward kitchen supervisors. This food is prepared to serve definite portions, since each ward supervisor is instructed before each meal in portion size as well as plate arrangement. An hour before meal serving begins, the salad assistant and dessert assistant transport their products to the ward kitchens. These foods are placed on trays shortly before the serving of hot foods begins. Fifteen minutes before meal serving is to commence, the three heated food trucks will have been loaded in the main kitchen by the chef and assistant cook. These food trucks consist of a heated top in which are assorted rectangular wells and a cupboard-like heated bottom section.

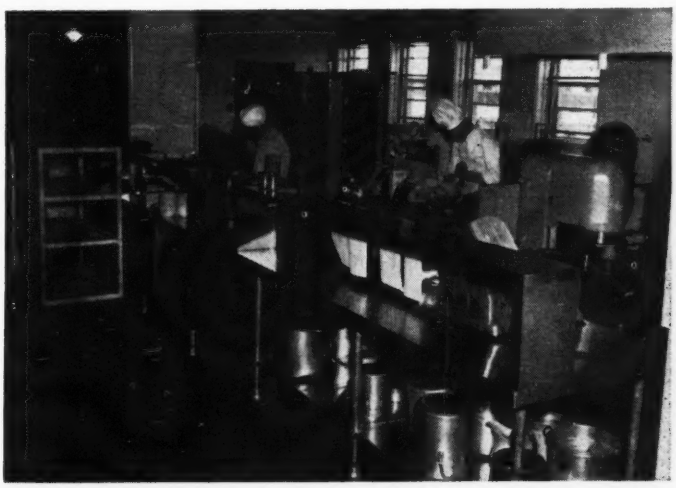
Tray service commences at exactly the same time on each floor. Trays are served by the food supervisors, who work a split shift in order to be present for each meal. The administrative dietitian gives intermittent supervision daily. Distribution of trays is accomplished by the housekeeping staff and collection of trays by the nursing staff. All trays (capacity approximately 200) are washed and reset in the ward kitchens.

Last, but certainly not least in the food service program, is the staff cafeteria. It is located on the main floor, and close to the main kitchen. Operated for all staff members, the cafeteria is open sixteen hours daily, and has a staff of eight plus a nutritionist supervisor. This latter staff member is also menu planner and therapeutic diet assistant. Two dining rooms, a smaller one with pale green walls and tan furnishings, and a larger one in shades of rose with blue and tan furniture, will seat 136 people. Draperies are of abstract design. The presence of radio facilities adds to the attraction of each room.

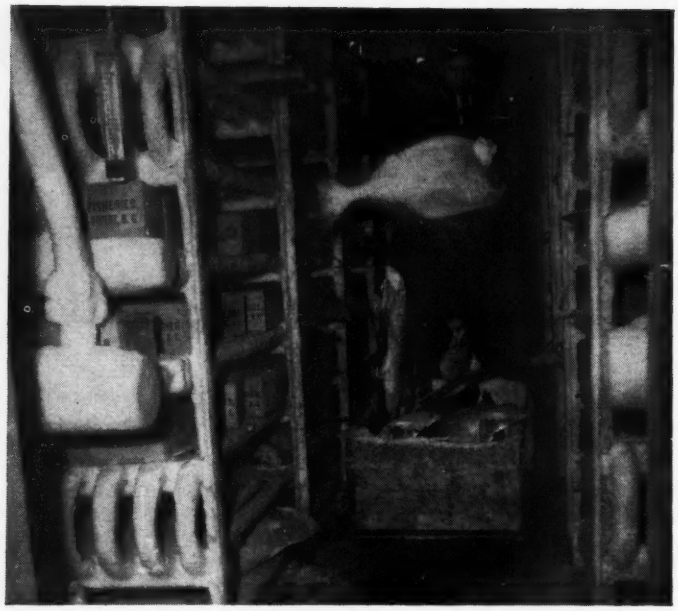
The gleam of steel in the cafeteria serving counter illustrates the attractive use of functional material.

The food dispensing area of the cafeteria consists of a stainless steel serving counter equipped with steam table, glassed-in shelves, tray and silverware compartments, coffee and water urns of similar size to those in the ward kitchens, and cash register area. Stainless steel cupboards, ice cream freezer, and heated cup wagon are also part of the equipment. There is a four-door refrigerator cupboard at one end of the counter. The dishwashing room is immediately behind the counter area, but is a separate room in itself. Soiled trays are passed through a receiving window. This room has a single tank dishwasher and prewash sink set in a stainless steel counter.

That the dietary department has run smoothly almost from the very first, with minor kinks being ironed out as the months progress, is a tribute to the loyalty and effort of all those concerned in food preparation and administration. We feel that the standard of food service is high, and through short weekly staff meetings, intermittent educational films and lectures, and close supervision of food service, we hope to keep it that way.



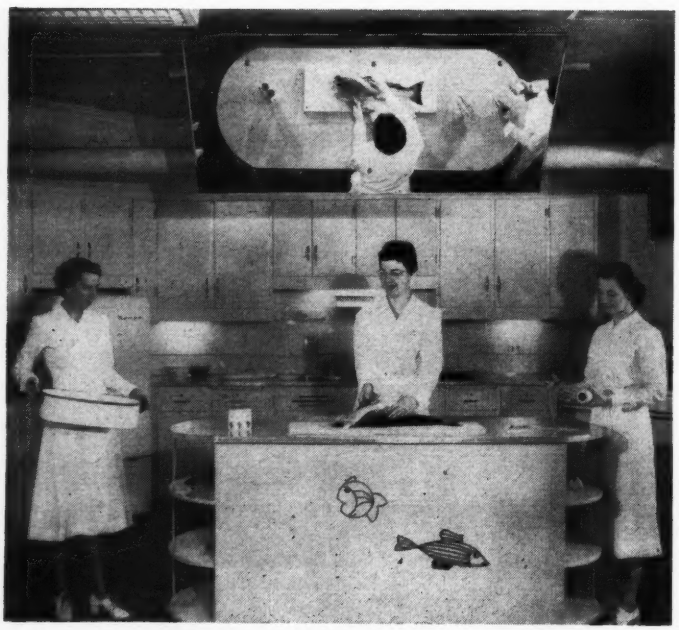
Main kitchen, showing preparation area with quarry tile floor, ceramic tile walls, and stainless steel counters and tables.



Frozen Fish Holding Room in Cold Storage Plant

Quick-Freezing Fillets

FISH *and temperature*



Test Kitchen, Department of Fisheries, Ottawa

HOW do fish dinners rate with patients and staff in your hospital? Are they popular, or do the guests grumble a little at the sight of them? In the latter case, it is a safe guess that somewhere along the line, from the time the fish was caught until it was served, something was wrong with the temperature. Fish of prime quality, tastefully prepared, is delicious fare. Serving it at its best would be less of a problem if everyone were aware of the delicate nature of this food. To explain, let us first take a look at a freshly caught fish.

A cursory examination reveals that the eyes and colouring of the skin are bright, the scales adhere tightly and have a silvery sheen. When the firm body is prodded, finger impressions do not remain; it does not smell unpleasant. Were one to clean this fish and cook it immediately — just to the point where the flesh loses its watery look (taking on an opaque hue) and will flake upon testing with a fork— you would find it tender and succulent. If it were only possible to preserve this quality of fish fresh-caught, its popularity as a food would increase enormously. But unfortunately, deterioration and eventual spoilage occur as the result of the inroads of bacteria and the action of ferments called enzymes. The rate of this deterioration is speeded by warmth and retarded by cold.

Temperature and Fresh Fish

It is a well known fact that fish spoils more rapidly at ordinary refrigerator temperature than do most other foods. Why this is so has to do with the type of bacteria found in fish. Being cold-blooded creatures, fish thrive in chill waters. In ocean areas where many of our fish are caught, the temperature usually ranges between 34 degrees and 45 degrees F. throughout the year. Bacteria that come with fish from the ocean therefore thrive at ordinary refrigerator temperatures of 35 degrees to 40 degrees F. and many types grow slowly at 32 degrees F., which is the temperature of melting ice.

Ordinary refrigeration for foods contaminated with bacteria which grow normally at room temperature (65 degrees to 75 degrees F.) or blood heat (98 degrees F.) greatly prolongs their keeping quality because reduced temperature stops or retards the growth of the bacteria. But ordinary refrigeration for fish, contaminated with the cold-loving types of micro-organism, is of little avail. To slow up significantly the growth of these cold-loving bacteria, the holding tempera-

Prepared by Information and Educational Services, Department of Fisheries, Ottawa.

ture of fish must be reduced below the temperature of the water from which they were taken. A holding temperature close to the freezing point of the flesh (29 degrees F.) is recommended. Practical applications of this information from the standpoint of a hospital dietition are as follows:

Shipments of fresh fish should be examined for quality before being accepted. The fish should be in a thoroughly chilled condition and show no signs of spoilage. They should come packed in clean, finely crushed ice or be otherwise refrigerated so that the temperature is not above 32 degrees F. or below 29.5 degrees F.

If more than the daily requirement is purchased at a time, the fish that is held should be kept well iced, using finely crushed ice. A point worthy of mention is that fillets and cut fish should be kept from direct contact with the ice, to avoid loss of soluble food elements through leaching. A layer of moisture-vapour-proof material under and over each layer of fillets or cut fish will solve this problem.

Dr. Hugh Tarr, director of the Vancouver technological station of the Fisheries Research Board of Canada, has demonstrated by recent experiments that the antibiotic, aureomycin, added to the ice used for packing fish, in an amount as small as one part per million, has a remarkably preservative effect. At time of writing, the Canadian Food and Drug Administration had not officially approved the use of aureomycin for food preservation. When this group is convinced that the gold-coloured chemical, in small amounts, is not injurious to human health, it is expected that widespread use will be made of it.

Temperature and Frozen Fish

At best, chilling of fish is a short-term preservation method only. Preservation by freezing is believed to be the answer to the problem of supplying fish, particularly seasonal varieties, everywhere and in all seasons. Freezing will arrest the activity of the bacteria and enzymes. This, however, does not necessarily mean that the product will have superior quality. Freezing can only fix the quality of a food product as at time of freezing. A fresh fish entering the freezer will come out fresh frozen; a stale fish will come out frozen but at the same time —stale.

Mr. Otto C. Young, assistant chairman of the Fisheries Research Board of Canada, who is internationally known for his work in refrigeration, tells us that physical and chemical analyses of frozen and thawed fish muscle indicate that rapid freezing methods for fish give best results. During the cold storage period which follows freezing, deterioration—if it does occur—will likely come about as the result of the dehydration of the flesh or oxidation (manifested by rancidity) of its fat content.

Mr. Young further tells us that provided the frozen fish have been given an adequate protective covering (in commercial practice, whole fish are glazed with a non-cracking coat of ice and fillets and steaks are sealed in moisture-vapour-proof materials) both ill effects mentioned can be minimized by storing the fish at sub-zero degrees Fahrenheit. He says that at the present time, technologists are working on the effect of temperature levels on fish proteins, in attempts to determine why it is so necessary to store frozen fish at the sub-zero level. To his knowledge, completely acceptable explanations are not yet available.

There are valid scientific reasons why thawing and re-freezing, or wide fluctuation in the cold storage temperature have a deteriorating effect on frozen fish but they are too lengthy to be included here. In conclusion, if fish of optimum quality is desired, it must be kept solidly frozen until ready for use.

Check These Points

In November 1955, the Canadian Government Specifications Board published a *Specification for Fish, Fresh, Frozen and Prepared.* This document, which is available from the National Research Council, Ottawa, at a cost of 15 cents, sets forth detailed requirements of fresh and frozen fish for the use of all Federal agencies. As a matter of interest, nine of these are quoted below:

1. Fresh fish shall be fish which has been thoroughly chilled as soon as possible after catching or removing from the water. Chilling shall be accomplished by packing in clean, finely crushed, fresh water ice, or by any other suitable method, so that the temperature is as near 32 degrees F. as possible, but in no case lower than 29.5 degrees F.

2. The fish shall have been maintained in a thoroughly chilled condition.

3. Frozen fish shall mean fish, which are strictly fresh and in prime condition at the time of freezing and frozen hard to the centre in one freezing at the earliest practicable time after catching or removing from the water.

4. The frozen fish shall be continuously maintained at a temperature not over 0 degrees F. during frozen storage, and not over 15 degrees F. during transit.

5. Frozen whole or dressed fish shall be protected by an adequate glaze during frozen storage.

6. The purchaser may specify the maximum total storage time for any frozen fish supplied under this specification.

7. The supplier shall furnish with each shipment a statement of the total storage time, to the nearest month.

8. A certificate or statement of inspection by a Fisheries Inspector immediately prior to shipment is required for each shipment of fresh, frozen or prepared fish.

9. Upon de-frosting, the total shrinkage of glazed, frozen, dressed or whole fish shall not exceed 8 per cent of the frozen weight.

This *Specification* while drawn up for the use of Federal agencies, may be adopted by institutions purchasing substantial quantities of fish. In cases where the size of a shipment warrants it (over 100 pounds) and inspectors are available in the district, the Federal Government will supply the institution with fish inspection without charge.

Cooking Temperature and Time are Vital

Despite the hard work of fisheries scientists, fishermen, fish processors and handlers, in the end it may be the cook who is the undoing of a good product. If he or she overcooks the delicate flesh or allows it to stand for lengthy periods on a steam table, what quality the fish may have possessed up to this will have deteriorated.

Fish, unlike meat, has no tough connective tissue to be broken down and hence does not require long, slow cooking. Overcooking toughens fish, dries it out and impairs the flavour.

As a result of cooking tests, the home economists of the Federal Department of Fisheries have found that fish has best flavour when cooked quickly and at a high temperature. They recommend a baking temperature of 450 degrees to 500 degrees F. A general rule for baking fish is to bake it at the above temperature allowing approximately 10 minutes baking time per inch of thickness if it is unfrozen and approximately 20 minutes per inch of thickness if cooking is begun when the fish is in the frozen state.

Frozen fish tends to be more flavourful when cooked without previous defrosting. The reason for this is that flavourful juices (which have a tendency to drip from the flesh on thawing) are better retained. When defrosting fish is necessary, it is good practice to cook it immediately. Otherwise there will be loss of quality and perhaps even spoilage.

At all stages, then, fish must be subject to temperature control, if optimum quality in the cooked product is to be obtained.

Menus For a Month

I

1st Saturday

Apple Juice
Cream of Wheat
Boiled Eggs
Toast
Black Currant Jam

Chef's Soup
Farmer's Sausage
Applesauce
Mashed Potato
Wax Beans
Red Jelly with
Whipped Cream

Tomato Soup
Eggs a la King
Green onions
Fruit Cup
Cocoanut Cookies

2nd Sunday

Orange
Dry Cereal
Bacon
Hot Rolls
Raspberry Jam

Chef's Soup
Roast Chicken
Gravy, Dressing,
Cranberry Sauce
Potato
Creamed Corn
Ice Cream

Cr. of Mush. Soup
Cold Meat
Potato Salad
Sliced Tomatoes
Pineapple
Ice Box Cookies

3rd Monday

Prune Juice
Vita-B Cereal
Bacon
Toast
Apricot Jam

Chef's Soup
Roast Lamb, Gravy,
Mint Jelly
Mashed Potato
Turnips
Vanilla Pudding with
Maraschino Cherry

Cream Pea Soup
Spanish Rice
Hard cooked Egg
Slices
Celery Hearts
Applesauce
Cup Cakes

4th Tuesday

Blended Juice
Old York Cereal
Eggs
Toast
Honey

Chef's Soup
Spareribs, Gravy,
Dressing,
Mashed Potatoes
Green Peas
Fruit Jelly with
Whipped Cream

Chicken Soup
Cold Meat
Baked Potato
Cole Slaw
Apricots
Shortbread

5th Wednesday

Grapefruit Halves
Rolled Oats
Bacon
Toast
Black Currant Jam

Chef's Soup
Roast Beef, Gravy,
Horseradish
Mashed Potatoes
Cauliflower
Ice cream

Cream of Mushroom
Soup
Macaroni and Cheese
Sliced Tomato
Pears
White Cake with
Cocoanut Icing

6th Thursday

Apple Juice
Dry Cereal
Bacon
Toast
Marmalade

Chef's Soup
Irish Stew
Baked Potato
Carrots
Ginger Bread with
Whipped Cream

Creamed Asparagus
S.
Salad Plate:
Devilled Egg
Potato Salad
Sliced Cucumber
Sliced Tomatoes
Lettuce
Dressing
Plums,
Drop Cookies

7th Friday

Oranges
Cream of Wheat
Eggs
Toast
Raspberry Jam

Chef's Soup
Fillets of Sole
Tomato Sauce
Mashed Potatoes
Wax Beans
Chocolate Cream
Pudding
with Cocoanut

Cream Tomato Soup
Creamed Chicken on
Toast
Radishes
Peaches
Iced Chocolate Cake

8th Saturday

Grapefruit Halves
Rolled Oats
Bacon
Toast
Strawberry Jam

Chef's Soup
Roast Veal, Gravy,
Apple Jelly
Mashed Potatoes
Diced Beets
Creamy Rice Pudding
with Maraschino
Cherry

Cream Mushroom
Soup
Shepherd's Pie with
Catsup
Green Onions
Fruit Cup
Marble Cake

9th Sunday

Orange Juice
Dry Cereal
Eggs
Toast
Peach Jam

Chef's Soup
Baked Virginia
Ham
Mustard Pickles
Mashed Potatoes
Fresh Spinach
Ice Cream

Cream Potato Soup
Salad Plate:
Cold Meat
Tossed Salad
Sliced Tomatoes
Carrot Sticks - Lettuce
Dressing
Cherries
Iced Shortbread

10th Monday

Apple and Lime
Juice
Cream of Wheat
Soft Cooked Eggs
Toast
Strawberry Jam

Chef's Soup
Roast Turkey, Dressing,
Cranberry Sauce
Mashed Potatoes
Peas, Carrots
Apples and Grapes

Cream Mushroom Soup
Salad Plate:
Cold Ham
Potato Salad
Tomato, Celery
Lettuce, Dressing
Pumpkin Pie with
Whipped Cream

11th Tuesday

Stewed Prunes
Rolled Oats
Bacon
Toast
Apple Jelly

Chef's Soup
Meat Loaf
with Tomato
Sauce
Baked Potato
Glazed Onions
Banana Cream
Pudding
with Banana Slices

Cream Pea Soup
Turkey à la King
Carrot and Raisin
Salad
Pineapple Slices
Spice Cake

12th Wednesday

Oranges
Dry Cereal
Soft Cooked Eggs
Toast
Marmalade

Chef's Soup
Sausages, Apple Sauce
Mashed Potatoes
Creamed Celery
Apple Crisp with
Butterscotch Sauce

Cream Tomato Soup
Spanish Rice
Cold Meat
Cole Slaw
Pears
Raisin Cookies

13th Thursday

Apple Sauce
Vita-B Cereal
Bacon
Toast
Black Current Jam

Chef's Soup
Roast Beef, Gravy
Horseradish
Roast Brown Potato
Macedoine
Strawberry Ice Cream

Cream Celery Soup
Salad Plate:
Salmon Salad
Cucumber and Tomato
Slices
Radish Rose
Carrot Sticks
Lettuce, Dressing
Apricots
Iced White Cake

14th Friday

Orange Juice
Cream of Wheat
Soft Cooked Eggs
Toast
Honey

Chef's Soup
Poached Haddock
Parsley Sauce
Mashed Potatoes
Harvard Beets
Lemon Jelly with
Whipped Cream

Vegetable Soup
Macaroni and
Cheese
Celery Hearts,
Radishes
Fruit Cup
Fruit Bread

15th Saturday	16th Sunday	17th Monday	18th Tuesday	19th Wednesday	20th Thursday	21st Friday
Blended Juice Old York Cereal Soft Cooked Eggs Toast Red Currant Jelly	Grapefruit Halves Dry Cereal Bacon Toast Cherry Jam	Tangerine Juice Rolled Oats Soft Cooked Eggs Toast Honey	Grapefruit Juice Cornmeal Bacon Toast Raspberry Jam	Apple Juice Dry Cereal Soft Cooked Eggs Toast Peach Jam	Stewed Prunes Rolled Oats Soft Cooked Eggs Toast Cherry Jam	Blended Juice Vita-B Cereal Bacon Toast Marmalade
Chef's Soup Liver and Bacon Mashed Potatoes Baked Squash Ice Cream	Chef's Soup Roast Chicken, Dressing Mashed Potatoes Wax Beans Orange Bavarian with Orange Section	Chef's Soup Roast Pork, Gravy, Apple Sauce Mashed Potatoes Peas Peach Meringue with Peach Slice	Chef's Soup Swiss Steak, Gravy Carrots Mashed Potatoes Fruit Jelly with Whipped Cream	Chef's Soup Roast Lamb Mint Jelly Roast Brown Potatoes Cauliflower Ice Cream	Chef's Soup Beef Stew Mashed Potatoes Baked Tomatoes Lemon Snow with Custard Sauce	Chef's Soup Fillets of Sole Egg Sauce Mashed Potatoes Spinach Butterscotch Pudding with Cocoanut
Chicken and Rice Soup Tomato Rarebit on Toast Waldorf Salad Cherries Shortbread	Cream Asparagus Soup Salad Plate: Cold Meat Tossed Greens Tomato, Cucumbers Celery Sticks Lettuce, Dressing Prune Plums Spice Cake	Cream Celery Soup Spaghetti and Meat Balls Green Onions Grapes Doughnuts	Chicken Noodle Soup Creamed Salmon on Toast Tomato Slices Apple Sauce Iced Chocolate Cake	Cream Mushroom Soup Salad Plate: Cold Meat Tomato Aspic Sliced Cucumbers Carrot Sticks Green Pepper Ring Pears Shortbread	Vegetable Soup Baked Beans and Bacon Celery Hearts White Cake with Jam Topping	Cream Tomato Soup Grilled Cheese Sandwich Tossed Green Salad Cherries Arrowroots

22nd Saturday	23rd Sunday	24th Monday	25th Tuesday	26th Wednesday	27th Thursday	28th Friday
Orange Cream of Wheat Soft Cooked Eggs Toast Apple Jelly	Tomato Juice Dry Cereal Bacon Toast Apricot Jam	Grapefruit Halves Old York Cereal Soft Cooked Eggs Toast Black Currant Jam	Pineapple Juice Rolled Oats Eggs Toast Cherry Jam	Apple and Lime Juice Cornmeal Bacon Toast Plum Jam	Apple Sauce Dry Cereal Eggs Toast Red Currant Jelly	Prune Juice Cream of Wheat Bacon Toast Honey
Chef's Soup Roast Beef Horseradish Roast Brown Potatoes Turnips Creamy Rice Pudding with Chopped Nuts	Chef's Soup Roast Chicken, Dressing Mashed Potatoes Cauliflower au Gratin Ice Cream	Chef's Soup Roast Veal, Gravy Red Currant Jelly Mashed Potatoes Green Beans Prune Whip with Custard Sauce	Chef's Soup Spareribs Baked Potato Creamed Corn Bread Pudding with Jam	Chef's Soup Roast Lamb Mint Jelly Boiled Potato Creamed Celery Ice Cream	Chef's Soup Roast Beef, Gravy Yorkshire Pudding Mashed Potatoes Cauliflower Jello with Whipped Cream	Chef's Soup Swordfish with Lemon Mashed Potatoes Scalloped Tomatoes Chocolate Cream Pudding with Cocoanut
Cream Asparagus Soup Cold Ham Scalloped Potatoes Cole Slaw Peaches Spice Cake	Cr. Pea Soup Salad Plate: Cold Meat Perfection Salad Celery Sticks Carrot Sticks Tomato Slices Pineapple Muffins	Cream Tomato Soup Chicken à la King on Toast Tomatoes Lettuce Apricots Shortbread	Cream Mushroom Soup Salad Plate: Cold Meat Tossed Greens Tomato Wedges Cucumber Slices Lettuce, Dressing Fruit Cup Vanilla Cookies	Cream Asparagus Soup Shepherd's Pie Green Onions White Cake Prune Plums	Chicken and Rice Soup Salad Plate: Cottage Cheese Grapefruit and Orange Sections Grapes, Apple Wedges ½ Pineapple Ring Banana Log Ginger Bread with Sauce	Vegetable Soup Welsh Rarebit with Ham Cabbage and Orange Slaw Fresh Grapes White Cake

These menus were compiled for Humber Memorial Hospital, Toronto, Ont., October 1955.

(*Concluded on page 50*)

Menus For a Month
II
Selective Menus

1st & 29th Saturday	2nd & 30th Sunday	3rd & 31st Monday	4th Tuesday	5th Wednesday	6th Thursday	7th Friday
Apple Juice Rolled Oats Muffets Eggs, any style Jelly Dry Toast, Buttered Toast, Rolls, Coffee, Milk, Cocoa *	Grapefruit Half Cream of Wheat Corn Flakes Eggs, any style Bacon Honey	Grape and Pineapple Juice Rolled Oats Puffed Wheat Eggs any Style Marmalade	Stewed Prunes Roman Meal Rice Krispies Eggs, any Style Bacon Jam	Pineapple Juice Farina Shreddies Eggs, any Style Honey	Orange Halves Rolled Oats Corn Flakes Eggs, any Style Bacon Jelly	Apple Juice Cream of Wheat Muffets Eggs, any Style Jam
Pepperpot Soup Lamb Chops Sautee *or* Roast Pork, Gravy Roast Brown Potatoes Mashed Turnip Baked Tomato Honeydew Melon and Canteloupe Pink Almond Junket White Bread, Whole Wheat Bread, Tea, Milk, Cocoa **	Tomato Bouillon Grilled Steak with Mushroom Fluffy Potatoes Cauliflower with Cheese Sauce Tossed Salad Fruit Delight Orange Sherbet	Oxtail Soup Canadian Style Back Bacon *or* Roast Veal Gravy, Sweet Pickles Steamed Potatoes Buttered Wax Beans Harvard Beets Marshmallow Cream Custard	Scotch Broth Grilled Pork Chop *or* Roast Beef, Gravy Horseradish Browned Potatoes Creamy Corn Lettuce Wedge with 1000 Island Dressing Deep Apple Pie Cheese Chocolate Junket	Tomato Juice Roast Lamb, Gravy *or* Breaded Veal Cutlets Whipped Potatoes Fresh Cauliflower Vichy Carrots Chocolate Blanc Mange Lime Jello Parfait	Mulligatawny Soup Swiss Steaks *or* Baked Ham, Applesauce Roast Brown Potatoes Creamed Celery and Peas Tart Cabbage Peach Crisp Custard	Fruit Juice (apple and grapefruit) Baked Stuffed Whitefish, Lemon Wedge Spicy Meatloaf with Mushroom Sauce Mashed Potatoes Scalloped Tomatoes Buttered Turnips Baked Lemon Pudding Maple Walnut Ice Cream
Cream of Vegetable Soup Hot Chicken Loaf, Cucumber Sauce Green Beans Baked Sweet Potato *or* Fruit Salad Supreme Chocolate Ice Cream with Marshmallow Sauce Sugar Cookies Lemon Parfait	Orange and Lemon Fruit Juice Hot Dog Deluxe Saratoga Chips Dill Slice Fried Onions Tomato Wedges Sunday Supper Salad Gingerbread with Lemon Sauce Jello Cubes	Apple Juice Fresh Steamed Salmon Tartar Sauce Scalloped Potatoes *or* Combination Salad Plate Tokay Grapes Iced Cup Cakes	Cream of Tomato Soup Chicken a la King Hot Tea Biscuit Broccoli, Olives and Celery Curls *or* Assorted Sandwich Plate Raspberry Sundae Pineapple Jello	Corn Chowder Barbequed Spareribs Steamed Rice Soya Sauce Cold Canned Tomatoes *or* Jellied Fruit Salad Cherry Roll with Sauce Lime Sherbet	Cream of Pea Soup Hot Beef Sandwich Tomato Wedges French Fried Potatoes *or* Tomato Aspic Salad Plate Fruit Cup (Peaches, Grapes, Banana, Pineapple) Sandies (shortbread) Peppermint Junket	Cream of Celery Soup Cheese Sauce on Toast with Asparagus and Bacon *or* Rainbow Fruit Salad Date Marshfallow Roll with Sauce Jello Cubes

*These choices of bread and beverages were available with each breakfast menu.

**These choices of bread and beverages were available with each lunch and dinner menu.

The menus given here were compiled for the month of October, 1955, by the University of Alberta Hospital, Edmonton, Alta. Non-selective menus were also available to patients.

8th Saturday	9th Sunday	10th Monday	11th Tuesday	12th Wednesday	13th Thursday	14th Friday
Grapefruit Juice Sunny Boy Puffed Rice Eggs, any Style Bacon Marmalade	Orange Juice Wheatlets Bran Flakes Eggs, any Style Bacon Honey	Pineapple Juice Corn Pops Farina Eggs, any Style Jam	Apple Sauce Rolled Oats Puffed Wheat Eggs, any Style Bacon Honey	Grapefruit Juice Brex Rice Flakes Eggs, any Style Marmalade	Orange Halves Wheatlets Muffets Eggs, any Style Jam	Apple Juice Rolled Oats Corn Flakes Eggs, any Style Bacon Jelly

Honey

Marmalade

Eggs, any Style
Jam

Eggs, any Style
Bacon
Jelly

Chicken and Rice Soup
Roast Beef Gravy
or Pork Sausages with Apple Rings
Boiled Potatoes
Browned Parsnips
Buttered Green Beans
Pineapple upside down Cake
Butterscotch Junket

Consomme
Roast Turkey, Gravy, Dressing, Cranberry Sauce
Mashed Potatoes
Broccoli
Sliced Tomatoes on Lettuce
Pumpkin Pie with Whipped Cream
Lime Sherbet

Orange and Grapefruit Juice
Baked Virginia Ham *or* Steak and Kidney Pie
Browned Potatoes
Kernel Corn
Buttered Peas
Pineapple Rice Dessert
Ice Cream

Split Pea Soup
Hot Spiced Tongue *or* Roast Beef and Gravy
Steamed Potatoes
Carrot Rounds
Brussels Sprouts
Loganberry Cobbler
Custard

Beef and Vegetable Soup
Roast Pork and Gravy *or* Irish Stew
Fluffy Potatoes
Fresh Frozen Wax Beans
Cabbage Slaw
Tokay Grapes
Banana Junket

Pineapple-Lime Juice
Grilled Liver and Onions *or* Chicken Pot Pie
Roast Brown Potatoes
Buttered Parsnips
Broccoli
Baked Chocolate Pudding
Orange Sherbet

Pepperpot Soup
Fried Fish Fillet, Tartar Sauce
or Roast Veal, Gravy
Mashed Potatoes
Julienne Beets
Tossed Salad
Pineapple Graham Dessert
Tutti Fruitti Ice Cream

Blended Juice-Grape, Apple and Pineapple
Austrian Ravioli
Frosted Peas
or Vegetable Salad Plate
Pears in Red Jello with Custard Sauce
Baked Custard

Cream of Mushroom Soup
Assorted Cold Meat
Cold Ham, Cold Beef
Baked Sweet Potato
or Golden Harvest Salad
Lemon Parfait
Chocolate Eclairs

Cream of Potato Soup
Tuna Casserole with Noodles, Baked Tomato *or* Cold Meat Cuts with Potato Salad
Cottage Pudding with Fruit Sauce
Strawberry Junket

Cream of Tomato Soup
Savoury Baked Beans and Hamburgers *or* Fruit Salad Supreme
Ice Cream Sundae
Doughnuts
Jello Whip

Cr. of Asparagus Soup
Mixed Grill—Sausages, Veal Tenderloin, Bacon, French Fried Potatoes, Chili Sauce *or* Chef's Salad Plate
French Apple Pie
Custard

Clam Chowder
Swiss Steak with Pan-Fried Potatoes
Baked Squash
or Spiced Peach Salad
Matrimonial Cake a la Mode
Jello Cubes

Tomato Juice
Sweet Potato and Sausage Casserole
Brussels Sprouts *or* Vegetable Salad Plate
Stewed Rhubarb
Walnut Slice
Pineapple Junket

15th Saturday	16th Sunday	17th Monday	18th Tuesday	19th Wednesday	20th Thursday	21st Friday
Blended Juices—Grape, Pineapple, Apple Roman Meal Rice Krispies Eggs, any style Marmalade	Half Grapefruit Cream of Wheat Shreddies Eggs, any Style Bacon Honey	Orange Juice Rolled Oats Corn Pops Eggs, any Style Bacon	Prunes Sunny Boy Puffed Rice Eggs, any Style Marmalade	Pineapple Juice Farina Bran Flakes Eggs, any Style Bacon Honey	Half Grapefruit Rolled Oats Rice Krispies Eggs, any Style Jam	Apple Juice Brex Puffed Wheat Eggs, any Style Bacon Marmalade
Beef and Noodle Soup Roast Lamb, Mint Sauce and Gravy *or* Corned Beef, Mustard Steamed Potatoes Buttered Cabbage Fresh Frozen Peas Steamed Date Pudding Fruit Parfait	Fruit Cocktail Broiled Tenderloin Steak, Mushrooms Browned Potatoes Corn on the Cob Baked Tomato Cherry Meringues with Whipped Cream Orange Jello Cubes	Vegetable Julienne Roast Beef, Brown Gravy *or* Hot Meat Loaf, Spicy Sauce Whipped Potatoes Buttered Green Beans Celery and Carrot Sticks Raisin Rice Pudding Custard	Oxtail Soup Glazed Ham, Slice or Roast Veal, Gravy Boiled Potatoes Spinach with Vinegar Julienne Parsnips Butterscotch Spice Roll Lemon Jello	Tomato Bouillon Broiled Lamb Chops *or* Braised Shortribs of Beef Roast Brown Potatoes Harvard Beets Brussels Sprouts Tokay Grapes Cherry Custard Ice Cream	Scotch Broth Roast Turkey, Gravy *or* Breaded Pork Tenderloin Mashed Potatoes Buttered Turnips Fresh Frozen Peas Apple Crisp Orange Junket	Consomme Baked Alaska Cod Tartar Sauce *or* Salisbury steak with Brown Gravy Parslied Potatoes Julienne Carrots Lettuce Wedge with Dressings Jellied Lemon Pudding Maple Walnut Ice
Cr. of Mushroom Soup Pancakes with Syrup Bacon *or* Cottage Cheese Fruit Salad Plate Baked Stuffed Apple Spice Cookies Custard	Cream of Celery Soup Chicken and Rice Creole or Combination Salad Plate Minted Pear Sundae Lemon Junket	Cream of Tomato Soup Sweet and Sour Spareribs *or* Jellied Fruit Salad Plate Lemon Layer Cake Pineapple Sherbet	Apple Juice Cold Meat—Roast Beef, Pimento Loaf *or* Seafood Salad Plate Fruit Ambrosia Shortbread Cherry Junket	Cream of Pea Soup Grilled Steak, French Fried Potatoes *or* Fruit Salad Deluxe Lemon Chiffon Pie Baked Custard	Tomato Juice Savory Veal with Buttered Noodles *or* Salad Sandwich Plate Canned Peaches Snowballs Jello Parfait	Cream of Vegetable Soup Spanish Rice, Bacon *or* Sunshine Salad Plate Black and White Surprise, Maple Junket

22nd Saturday	23rd Sunday	24th Monday	25th Tuesday	26th Wednesday	27th Thursday	28th Friday
Grapefruit Juice Rolled Oats Muffets Eggs, any Style Honey	Orange Halves Wheatlets Corn Flakes Eggs, any Style Bacon Jelly	Pineapple Juice Sunny Boy Rice Flakes Eggs, any style Jam	Orange Halves Farina Shreddies Eggs, any Style Honey	Grapefruit Juice Rolled Oats Corn Pops Eggs, any style Bacon Jelly	Applesauce Wheatl ts Bran Flakes Eggs, any Style Marmalade	Orange Juice Brex Puffed Rice Eggs, any style Bacon Jam
Chicken Gumbo **Old Fashioned Stew** *or* Roast Pork, **Applesauce** Brown Potatoes Buttered Wax Beans Scalloped Tomatoes Peppermint Cream Lime and Lemon **Jello Cubes**	Chicken Gumbo Soup Breaded Veal Cutlet with Gravy Whipped Potatoes Broccoli **Jellied Vegetable Salad** Strawberry Shortcake Lime Sherbet	Consomme **Roast Ribs of Beef** Gravy—*or* Baked Spareribs Boiled Potato Buttered Carrots Cherry Dessert Cake **Sweet and Sour Cabbage** **Custard**	Vegetable Julienne Grilled Liver *or* Roast Lamb **Gravy, Mint Sauce** Mashed Potatoes Creamed Onions Buttered Peas **Prune Whip with Lemon** Custard Sauce Chocolate Junket	Beef and Noodle Soup Roast Veal, Gravy *or* Chicken Fricasse Browned Potatoes Cold Canned Tomatoes Buttered Beets Banana Floating Island Orange Jello Cubes	Fruit Juice Broiled Ham Slice *or* Pot Roast of Beef Gravy Horseradish Mashed Potatoes Mixed Vegetable (Corn, Onions, Lima Beans) Brussels Sprouts Peach Cobbler Pineapple Sherbet	Chicken Rice Soup Grilled Salmon Steak *or* Mock Duck Parslied Potatoes Savory Green Beans Fresh Vegetable **Orange Tapioca Cream** Lime and Lemon **Jello**
Orange and Grapefruit Juice Hot Vegetable Plate (**Scalloped Potato, Brussel Sprouts, Diced Carrots**) *or* **Chef's Salad Plate** Fresh Apple Bran Muffins **Custard**	**Cream of Mushroom Soup** Lamb Fricassee Baked Potato *or* Fruit Salad Plate Butter Tart a la mode Vanilla Junket	Grape Juice and Gingerale, Scrambled **Eggs an Toast** Bacon Strips *or* Vegetable Salad Plate Chilled Fruit Cup Chocolate Brownie Pineapple Jello	Cr. of Tomato Soup **Baked Macaroni and Cheese** Sausages Fresh Frozen Asparagus *or* Fruit Baskets Salad Apple Dumpling with Whipped Cream Brick of the Month Ice Cream	Cr. of Asparagus Soup **Cold Beef and Pimento Loaf** Paprika Potatoes **Corn on Cob** *or* **Combination Salad Plate** Fresh Apple Cocoanut Macaroons Custard	Cream of Celery Soup **Chow Mein with Noodles** Steamed Rice, Soy Sauce Grilled Tomato Slice *or* Cottage Cheese Fruit Salad Plate Toasted Snow Squares with Orange Sauce Maple Junket	Tomato Juice Hot Vegetable Plate (Bacon-Fried Potatoes-Green Peas-Carrots) *or* **Devilled Egg Salad** Rhubarb Pie Custard

(*concluded from page 47*)

P.C.

29th Saturday		30th Sunday		31st Monday	
Oranges Rolled Oats Eggs **Toast** Peach Jam	Cream Pea Soup Wieners and Buns Mustard and Relish Tossed Greens Fresh Apples Drop Cookies	Tomato Juice Dry Cereal Bacon Toast Strawberry Jam	Chef's Soup **Roast Chicken, Dressing** Mashed Potatoes Brussel Sprouts Ice Cream	Orange Juice Vita B. Cereal Soft Cooked Eggs Toast Apricot Jam	Chicken Noodle Soup Spanish Rice Bacon Chef's Salad Peaches Marble Cake
Chef's Soup Meat Patties, Gravy Baked Potatoes Diced Beets Tapioca Cream Pudding with Maraschino Cherry			Cream Celery Soup Salad Plate: Cold Meat Potato Salad Tomatoes Jelly Roll	Chef's Soup Roast Beef, Gravy Mashed Potatoes Glazed Onions Grape Sponge with Custard Sauce	

P.C.

Twenty-First Convention of the

Canadian Dietetic Association

Wilda Fitch
Dietitian
Sunnybrook Veterans Hospital
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THE 21st "coming of age" convention of the Canadian Dietetic Association was held in Edmonton from June 26 to 28, 1956, in the McDonald Hotel.

Presiding was Jean King of the T. Eaton Co. Ltd., Toronto. An important item of business was the election of the new president, Jean Macdiarmid of the Department of Veterans Affairs, Ottawa, and her executive. The annual reports of the association committees, which were given in detail at the preceding meeting of the board of directors, were also of great interest to dietitians, being a good indication of the many professional activities carried on by dietitians outside of business hours. These include the publishing of the C.D.A. journal six times a year; committees to set standards for university education and internship training; a nutrition committee which, working jointly with the nutrition committee of the Canadian Home Economics Association, did a study of food misinformation in Canada; vocational guidance and public relations committees to inform the public of the work of the dietitian; also, an equipment advisory committee which keeps a file on new equipment available and a committee on emergency feeding in Civil Defence concerned with courses in emergency feeding held in Arnprior for food workers.

Many interesting speakers supplied new ideas and information to the 200 delegates. The speaker at the opening luncheon was M. J. Marshall, British Trade Commissioner in Edmonton, who stressed the importance of Canadian buyers purchasing more goods from Britain to improve the dangerous trade balance of 2 to 1 which exists at present. Canada sold $800,000 000 last year and bought only $400,000,000. This will result in a shortage of Canadian dollars in Britain with a resulting drop in British ability to buy Canadian goods, although Britain is our biggest market for wheat.

A panel on "Nutrition of the Surgical Patient" was chaired by Dr. W. C. MacKenzie of the University of Alberta. In discussing ulcer diets, the panel disagreed with the theory that total calories are more important than the type of foods, and stressed frequent bland foods with a good proportion of protein and fat, since fat depresses acid secretion and slows down stomach motility. The typical ulcer personality was mentioned, since this patient is often fairly fastidious and likes a 1-2-3 regime with individual instruction, rather than a mimeographed sheet. Alcohol should be avoided since it stimulates gastric secretion, but after healing, a highball on a full stomach might be allowed.

The post-gastrectomy diet described consists of 5 small dry feedings with a small volume of concentrated foods although low in concentrated sweets which may ferment and cause gas.

After the removal of the gall bladder the patient should be able to ingest more fat than previously, with limited amounts at a time, since there will be a continuous flow of bile into the intestine. If side effects occur in any diet it is up to the dietitian to find the reason and correct it.

Surgery is no longer such a risk for the diebetic patients, but extra care is required. The liver must be well stocked with glucose and glycogen, so 200 to 300 grams of glucose with extra insulin may be given pre-operatively. After the operation, oral feedings should be started as soon as possible and the diet and insulin regulated to prevent the formation of boils and carbuncles now that the antibiotics are not so effective against these.

Dr. H. N. Tarr of the Fisheries Research Board of Canada discussed new methods of preserving flesh foods with the injection of antibiotics either directly into the veins of cattle after slaughter or into ice flakes in which the fish may be packed. This may be of very great importance to food marketing when the process has been refined.

Dr. R. E. Bell, University of Alberta Hospital, discussed "Atomic Energy in Medicine." The use of radio-active isotopes is becoming more widespread for malignant tumours, since actively dividing cells are more sensitive to radiation than normal ones. Sometimes the treatment is palliative rather than a cure, but the patient may be returned to active life for many years. Tracer atoms may be used to follow the course of an element through the body to study certain functions. Iodine, chromium, iron, cobalt may be used. Sterilization by radio-activity may also be a thing of the future, but at present is expensive and doesn't always result in a good flavour since enzymatic reactions may still occur.

Dr. Barbara McLaren of the University of Toronto spoke on "Recent Advances in Nutrition". A project in Air Force flight feeding disclosed that simple indigestion is a great problem of air force personnel, especially those who fly jets, since stomach gases increase in volume at high altitudes. Therefore gassy foods should be avoided. A dietary study of "Dietary Patterns of Senior Citizens" undertaken by the Ontario Dietetic Association showed that of pensioners without extra income only 33 per cent ate meat once a day, only 25 per cent ate citrus fruit, and only 50 per cent ate vegetables. Some ate up to 70 slices of bread a week.

"Keys to Management" was the topic of one morning's lectures. Prof. J. D. Campbell, U. of A., discussed the art of "Staff Management". First key to management—the dietary department is only one of many units to serve a specific service, and that main objective must be primary to personal desires and requirements. Second key—responsibilities must be delegated, although many find the delegation of authority difficult. The head must check to see that the duties are carried out. There should be a direct line of authority in the department, so that each employee knows whom to approach with a problem. It is none of the business of the head to answer problems out of line, as this undermines the authority of the direct supervisor. Third key—every individual in the organization must be treated as a person with the right to use his capacities and to hear and be heard about what actually concerns him. Initiative and loyalty cannot be bought.

Mr. J. D. Therrien, National Employment Service, described "The Placement of the Handicapped". These people are not a separate group who are easily distinguished since perfec-

(continued on page 98)

Food Service

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R. J. H. Overcomes Dining Problems

Mary E. O'Brien, B. Sc. in H. Ec.
and
L. Pearl Murray, B. Sc. in H. Ec.
Assistant Dietitians,
Royal Jubilee Hospital,
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AN attractive, tastefully decorated and efficiently run dining area can bring such comments as "Even the food tastes better now". This, along with other similar remarks, was recently heard throughout the corridors of the Royal Jubilee Hospital in Victoria, British Columbia. April of 1956 marked the completion, after two years of organizing and construction, of a new pay cafeteria.

The Royal Jubilee Hospital is a 529-bed, acute general hospital, with all services and a training school for nurses. Founded in 1858 and established on its present 20-acre site in 1890, it consists of a maze of buildings, some old, some new.

The need for a pay cafeteria had become more acute as beds were added to the hospital and staff increased. In the past, a number of separate dining rooms were provided and waitress service was used. During World War II such service could no longer be provided and a modified cafeteria was built, which offered the staff a hot meal but no selection. Meal tickets were used for employees and student nurses.

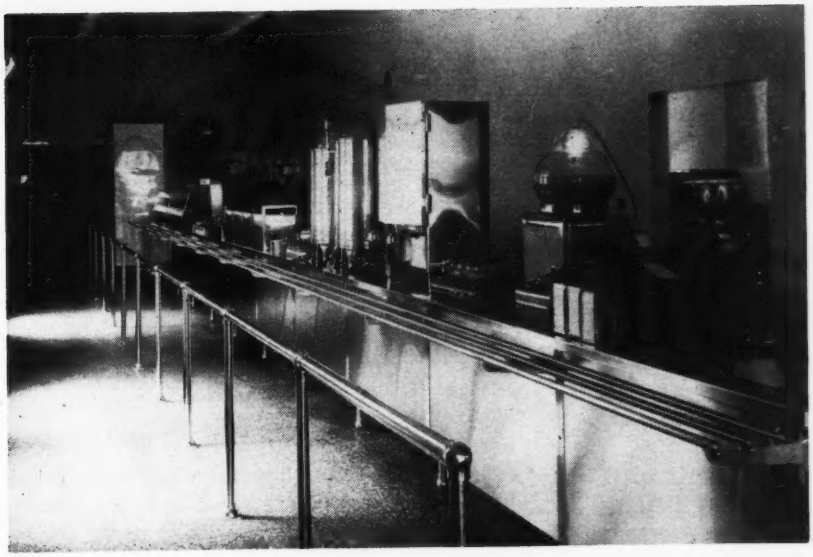
The development of a new cafeteria layout was the result of integrated planning and team work on the part of many people. The hospital team of administrator, assistant administrator, chief dietitian, chief engineer and purchasing agent was augmented by conferences with architects, kitchen engineers, equipment suppliers and decorators. Rough sketches were developed, scale plans were drawn, furniture placements planned to scale and studies made of the traffic flow. The Board of Directors insisted on high standards of construction of the stainless steel counter work, as examples of cleanliness and sanitation in the community.

The old dining area consisted of several small rooms, which had to be removed before construction on the new portion of the dining area could begin. During this time, the original food service and dining area was not affected, except for the inconvenience of noise and plaster dust. In October, 1955, the new portion of the dining area was ready for use. It was built of concrete blocks. An interesting feature of this construction was the use of special steel joists, which eliminates the necessity of posts or partitions to support the ceiling. The sub-flooring was of two-inch tongue and groove decking with plywood sheeting on top, to provide a smooth surface for the battleship linoleum in a marbled pattern. Acoustic plaster was sprayed on the ceiling. Thermostatically controlled heating is contained in low pressure coils behind sheet metal panels. The lighting is semi-indirect, with incandescent bowl fixtures.

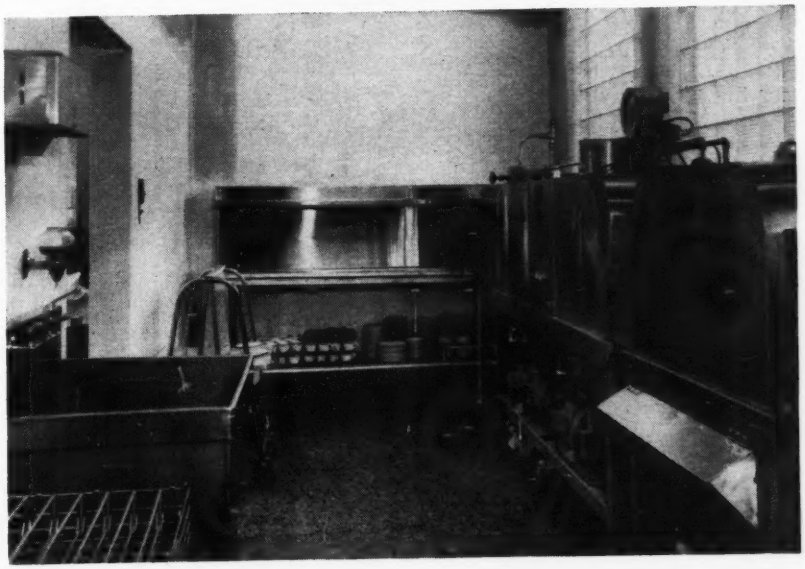
The walls were deliberately left neutral in a flat ivory shade, with the exception of two walls in a brown tone, the colour being picked up in the drapes and furniture. The drapes are on a modern, abstract print in tones of chartreuse, chocolate brown and coral on a neutral background. A cotton boucle drapery was used to cut down glare from the many windows. The table tops are of a platinum walnut arborite with black iron legs and the chairs of black iron square tubing upholstered in chartreuse vinyl plastic-coated fabric.

When the construction of the new dining area was complete, it was necessary to remove the old cafeteria tray-line, in order that the new dishwashing room could be built. A two-tank dishwasher and a "scrapper" were installed before the old dishwasher could be removed. The scrapper utilizes the hot detergent water from the dishwasher, pre-rinses and soaks the

Old and new dining areas, seating 255. The attractive floor and table surfaces enhance the uninterrupted view through the rooms.



Cafeteria counter. Note large refrigerated juice cooler, next to refrigerated milk and cream dispenser.



View showing the two-tank dishwasher used following the scrapper at right. Doorway at left leads to the serving area.

Counter from servery side. Seen here, from tray stack in background to cash desk at left, is the 43 foot stainless steel cafeteria tray line with provision for refrigeration, heating and storage space.

soiled dishes. An automatic solution control was installed to maintain the effective strength of the detergent (this removes human error). The automatic rinse injector was installed on the last rinse, introducing a liquid surface tension reducer or wetting agent, allowing the dishes to air-dry in seconds. The walls are made of an exceptionally hard plaster which does not absorb steam. The wicket for receiving the soiled trays opens into the dining area itself.

The entire food serving area was to be remodelled, therefore it was necessary to set up a temporary method of serving. This was accomplished by the use of two electrically heated conveyors and tables for the cold foods, set up in the old dining area. While this was taking place, the dining room staff lost some of their working area with each succeeding move and it became more difficult to serve the meals.

With all the furnishing removed from the old dining area, it was possible to continue with such renovations as were needed. This brick building had a fourteen-foot ceiling, magnesite composition floors, small windows, and inadequate lighting and heating. While the windows were being modernizd with new frames and sashes, the heating system was being changed. This condition, in January and February, became very trying for the dining room staff but they showed a great deal of patience and co-operated to the fullest extent. The actual dining area, which was the new addition, had been closed off, so that it was comfortably warm at meal time. The remodelling of the old dining area included repairing of plaster and the laying of similar battleship linoleum. A suspended ceiling of fibreglass tile, two feet by four feet, in a network of aluminum T-channels, was put in to lower the ceiling to approximately the same height as the one in the new area. The lighting fixtures and the heating system were the same as in the new dining area.

Two private dining rooms were constructed at one end, to be used for special luncheons, giving a total seating capacity of 255. The over-all effect of the new with the old seemed to flow together as one, with continuity of wall colours, drapes, furniture and flooring.

Results of long months of work and inconvenience to all were beginning to show with the appearance of the completely new cafeteria tray line. This line-up, 43 feet in length, with 12 feet of refrigerated counter and storage space, and 14 feet of heated counter space, has all stainless steel construction with stainless ball feet for ease of cleaning, and removable shelves in all sections. Joints or seams which are not removable are sealed to prevent dirt or vermin accumulation. It is interesting to note that this tray line was completely manufactured in British Columbia.

Food Service

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As the customer arrives at the cafeteria tray-line, she picks up her colourful green or gray tray from a trolley carrier (which gives ease in transporting trays from dishwasher to tray line). Behind and to the left of the trays, in a closed area, is the salad preparation unit. The salads are prepared and put in the refrigerated unit next to the trays. On this counter are to be found salads, sandwiches, butter and attractive desserts, fruits, doughnuts and cake, arranged in a colourful display. The ice cream refrigerator is attached to this unit. Directly behind is the sandwich preparation unit, made of stainless steel with a maple cutting board that may be easily removed for cleaning purposes. A refrigerated area is to be found under the cutting board for the storing of sandwich necessities. The cover, over the inserts for sandwich fillings, has two continuous hinges, so that it also may be easily removed for cleaning.

Next in line is the bread dispenser, which enables a customer to choose one of five different kinds of bread. This is followed by a lowerator for the bread and butter plates. A fifteen-inch square grill adjacent to this is used for short orders, mainly for the midnight meal. Now follows the electrically heated hot table with roll-up covers and space for four large pans of hot food or eight small pans. With this unit are heated lowerators for the soup bowls and dinner plates. The supply of cups is very handy in a heated dishrack lowerator followed by a lowerator for the saucers, which are directly next to the coffee and water urns. The customer now reaches a refrigerated milk dispenser with milk from two sources and cream in the centre of the door. The dishwashing room is located directly behind this unit. A short distance from the milk dispenser is a lowerator for tumblers. Adjacent to this is a refrigerated fruit juice cooler.

One big advantage of the cutlery baskets used is that the silver is not handled. The serviettes are then picked up and the customer proceeds to the cashier. The cash register in the cafeteria is completely new to this hospital. Consequently, it presented problems for student nurses and paying customers. This was solved by having the student nurses sign their bill, and in this way it protects both the cashier and the hospital. The students have no restrictions on the type or amount of food that they may choose. Directly behind the cashier are six steel cabinets for storage purposes.

This completes the cafeteria tray-line. Five pop-up toasters are provided throughout the dining room, so that the customers may have freshly made toast for breakfast. A durable, vitrified china of medium weight was chosen with a green and brown edging to blend in with the furnishings of the dining room.

A caterer-supervisor was engaged before the alterations had been completed to help re-organize and supervise the staff. It was necessary to provide two additional waitresses in order to give the service that this type of cafeteria requires.

For the past twenty years, the Royal Jubilee Hospital, in Victoria, British Columbia, has been meeting cafeteria problems as they arose. However, with an eye to long-range planning, this new cafeteria with its modern equipment and decor, will remain both serviceable and pleasing to the customers in the years to come.

B.C.G. Vaccination in Jordan

A two-year B.C.G., vaccination campaign, conducted under the technical direction of W.H.O., recently came to an end in Jordan. This campaign, which was also aided by U.N.I.C.E.F. and the United States International Cooperation Administration, was considered highly successful. More than 600,000 children under fourteen years of age were tuberculin tested and more than 300,000 vaccinated.

Dr. Jibran M. Farah, W.H.O. technical adviser, has reported that, as a result of the campaign, a special B.C.G. section has been set up in the Ministry of Health of Jordan to take care of vaccination needs in the future. This service is to be incorporated into a national anti-tuberculosis program in which 72 persons trained by international staff during the past two years are expected to work. —*Chronicle of the W.H.O.*

Food in Public Relations

THE vast majority of the world's inhabitants have never in their lives eaten what may be described as a "square meal". Much of the uncertainty and unrest in world politics and economics is attributable to this fact.

The magnitude of food's importance in the world shrinks almost to insignificance our own problems in the preparation and service in hospitals and elsewhere. However, man is exhorted in the Scriptures to make use of his talents; and, surely, doing one's best with what is available is an admirable human characteristic. This faculty must never be neglected. Procedures must be examined with a critical eye.

In evaluating a meal, there are several points to be considered. Even to one who is anything but an expert, three factors suggest themselves:

1. Nutritional value.
2. Cost, or economic value.
3. Value from the social or public relations viewpoint.

It is the latter point — the impact which a meal has on the individual and how it affects his attitude to his host — that will be considered here.

Few laymen would try to tell the doctor how to diagnose and treat his patient. But is there anyone who is not ready to discuss food service? Everyone is an expert here! There is a very wide range of ideas and personal preferences to be considered. In a hospital one may find the most modern services, the most beautiful nurses — but what the average patient remembers most vividly are the meals, particularly if they are poor. What factors are important in a meal placed before the "customer"?

First, quality — of the raw food, of care in initial preparation, and of skill in blending, cooking and serving.

Second, service — in the provision of sensible quantities, attractive arrangement on the plate, and the appropriate use of combinations of colours and flavours. Perhaps as important as the physical attractiveness of the meal itself is the act of placing it before the recipient. The tray should be served in a friendly manner by the staff, with apparent pride in its quality, and with an air designed to arouse interest and enthusiasm.

There is also the important matter of systematic tasting in the kitchen; the merits of china, plastics and silverware; the use of tray covers; and physical facilities for the reception, storage, and distribution.

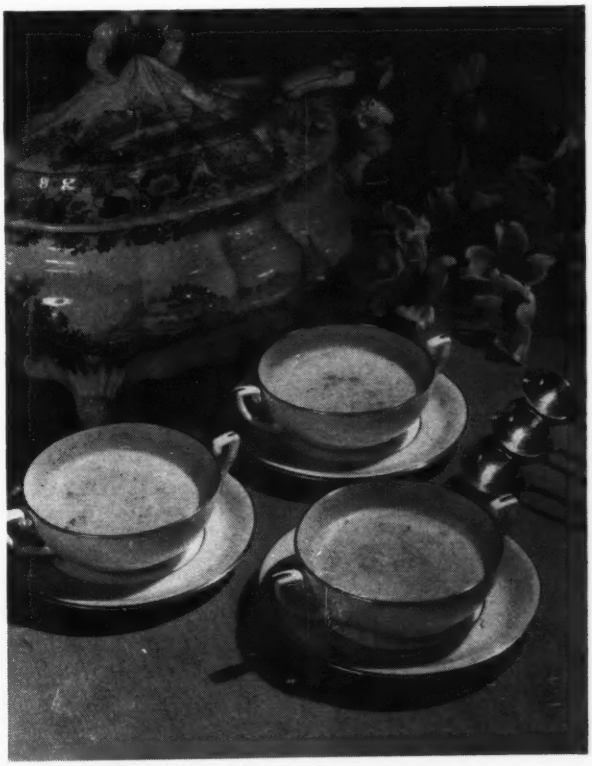
"People" form an important category in this connection. Here, greatest success will be achieved by a director who deliberately sets out to understand the people whom he supervises. Two basic personality needs of the average individual are security and success. Security here may be taken to mean a person's confidence that he is equal to life's demands. The need for success or achievement follows from this.

Individuals feel useless, and develop a sense of not being needed unless they have opportunities for achievement, and a chance to win appreciation. Thus, all in positions of responsibility over others must possess a knowledge of some aspects of the science which has come to be known as human relations. At the risk of over-simplification, their attitude towards their subordinates should be one of "respect"; respect for them as individuals, and for the tasks they perform.

But usually one must deal with groups of individuals, and here the expression "teamwork" will apply. A prominent Canadian businessman stated: "The major element in long-term business success is manpower, and the way it builds an effective team." Team work cannot be bought, it must be built — through training. An enterprise will resemble a school, in which skills and methods are constantly improved, integrating the whole into a productive team.

A dietary service in a hospital or elsewhere is no exception. Solve the personnel problem, and the difficult part of the battle is won. Food service makes an immediate and lasting impression in hospitals just as in hotels. Suspicion and apprehension are often present in the patient's mind. But he does understand food, though all else is strange. Perhaps he concentrates on the meals to compensate in part for his inability to comprehend the other things which are going on about him. Furthermore, he will talk about his meals afterwards. The hospital has here a contact with the public which it cannot avoid. It is dealing in public relations whether it wants to or not.

It is both a challenge and an opportunity. The hospital has here the means of winning approval for its services in the community. It is a public relations opportunity unique in that it is almost entirely within the hospital's control, and not dependent on the whim or skill of outside or independent forces — *M.W.R.*



Angostura also goes with celery soup.

Standardizing Recipes

The use of standardized recipes is an important step in producing good food service. Standard recipes list the ingredients, and give complete directions, thereby eliminating all guesswork in cooking.

A file of suitable and acceptable recipes is essential in keeping quality of products at a uniform high standard. Recipes are necessary in training new workers. They are particularly important in the production of uniform products considering the number of untrained workers in our kitchens. A recipe should include:

1. Amount of ingredients, either by volume or weight.
2. Method of combining ingredients.
3. Cooking or baking temperature.
4. Length of cooking or baking time.
5. Size of pan to be used and amount of food or batter for each pan.
6. Size of service portion and number of servings recipe will yield.
7. Space for calculated portion cost and date of cost accounting of recipe.

Recipes should be set up to yield the standard portions that will be required in your hospital. Each recipe should be analyzed from the standpoint of good kitchen management. This means thinking through details of production. These questions may help in recipe writing:

1. Are there procedures in the recipe that can or should be performed in advance? In making an upside-down cake, for example, the fruit topping would be prepared and placed in the pan before making the cake batter.

   All preliminary preparation should be listed first in the recipe.
2. Can the dish be prepared in advance? The recipe should indicate if a gelatine, dessert or gelatine salad should be prepared the previous day. In the preparation of croquettes, the recipe should indicate the chilling required for several hours or overnight before moulding.
3. Can the procedures be simplified or eliminated to save time and the use of equipment? The same beater may be used without washing by beating whites of eggs and then the egg yolks.
4. Are there further directions that should be indicated on the recipe? These might include the instructions specifying whether or not to grease the pans, suggestions of garnishes, or variations of the recipe, et cetera.

Reprinted from Kitchen Konversation, published by the Texas Hospital Association, Dallas, Texas.

Samples of Measuring Cost of Recipes

Beef Stew

Serving Portion: ¾ Cup (6 oz.) Yield: 50 Servings

Ingredients	Amount		Cost
Beef Chuck, cubed	12½ lbs.		$4.13
Onions, chopped	1¼ lbs.		.08
Fat	1 cup		.125
Water	2½ qts.		—
Tomatoes, canned	5 cups		.25
Salt	2 tbsp.		.003
Pepper, black	2 tsp.		.013
Potatoes, diced	3½ lbs.		.34
Carrots, diced	2½ lbs.		.135
Flour	⅓ cup		.01
		Total Cost:	$5.086
		Cost per serving	.102

Procedure:

1. Brown meat and onions in fat. Add water and cook until meat is almost tender.
2. Add tomatoes and seasonings. Add potatoes and carrots. Cook until tender.
3. Thicken with flour if necessary.

Developing a Standard Recipe File

One good way to develop a recipe file is to try the recipes available through reliable sources. Most of these recipes are institution-tested and may be satisfactory for your use without many adjustments.

Cookbooks written for home use may also be used. In this case, multiply the amount of the ingredients the number of times necessary and then try the recipe. You will probably want to make adjustments in the recipe and try it again. It is especially important to keep a record of what you have done when you are using this method of developing a recipe. As a general rule recipes for bakery products (cakes, cookies, muffins, et cetera,) should not be multiplied more than five times.

A third and very important source of recipes is your personnel. Many times the kitchen employees will have good recipe suggestions and they will take pride in helping you develop and standardize recipes. Again it is very important to measure accurately and keep a record of the recipe and the changes you have made.

The size and form of the recipe file will depend upon your personal preference. Recipes may be on 5 in. x 8 in. cards and kept in a standard recipe box or cardex. During the process of standardizing recipes, a loose-leaf notebook may be most helpful in keeping a complete record of the recipe development.

Measuring Cost of Recipes

Knowing your food cost is important. The trend today is toward pay cafeterias or a meal ticket system, even for small hospitals. You are responsible for keeping the food cost within your budget and this problem will be greatly simplified if you know the exact cost of the food that you are serving.

Figuring the cost can be done in a simple manner once you have standardized recipes and established exact serving portion control. You need only write the price of each ingredient in the recipe and total the amount, divide this sum by the number of portions the recipe will serve, and you have the cost of one serving. There should be space to make a note of the cost and the date of cost accounting on the recipe. If you make these notations in pencil you can easily make adjustments when food prices change. A price list of commonly used ingredients would help simplify the cost accounting of recipes.

At Ranch Style Hospital

Meal Service on Wheels

Food service wagon with chilled and heated compartments.

THERE will be no soupy ice cream or cold soup for patients at Queensway General Hospital which was officially opened Saturday, July 21. Special delivery wagons, equipped with chilled and hot food compartments, assure the food's delivery to the patient as it should be served — either piping hot or chilled.

The wagons may be described as cabinets with compartments for hot and cold foods, service trays, and beverages. Rectangular in shape, the wagons roll along on rubber-tired casters and are easily manoeuvered by one person. Thirty complete meals are carried in each wagon.

Dietitian Patricia Beckwith examines one of kitchen's huge soup kettles.

Although portable meal wagons have long been used, the basic model has been redesigned to meet requirements of the Queensway Hospital by A. H. Frampton, consulting engineer to the Board of Governors. In place of steel frames and sheeting, magnesium structural metal frames and aluminum sheathing have been substituted. As a result, each wagon weighs about 200 pounds less than its original counterpart. A half tray was designed to hold the cold components of the meals such as salad, salt, pepper, cream, bread, butter, custard, and the cutlery. As soon as this section is assembled, it is placed in the cold compartment which is chilled by panels of pre-frozen eutectic liquid.

While the dietitian is supervising the preparation of prescribed diets and name-tagging each plate, the wagons are plugged into electrical outlets to heat the hot food section, with the temperature thermostatically controlled. The hot foods are placed in the wagons on plates.

At meal time, members of the dietary staff wheel the wagons to the corridors where the half trays of cold foods, the hot plates, and beverages are added to the main tray and taken to the patient. With each food container tagged with the patient's name, the chief dietitian is not only able to provide prescribed diets for each patient but can keep an accurate record of the food consumed, an important factor in the patients' treatment. The wagons will carry approximately 500 meals a day.

Hospital Pharmacy Survey

Part II

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and
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Toronto, Ont.

REPLIES from hospitals which do not employ a pharmacist were received from 181 administrators. Of these 155 gave us some information which is recorded in Tables XIII, XIV, XV.

In Ontario, 48 hospitals are in this category, 22 of which have 50-99 beds and 5 over 1,000 beds. Only 3 in the 50-99 bed group reported that they have prescriptions filled at local pharmacies. However, some type of pharmaceutical service exists in these institutions and although not employing a pharmacist 2 hospitals reported that "the pharmacist is required to be in attendance at all times", and 9 "most of the time". One hospital reported that the "responsibility over and distribution of *all medicaments* is vested in a licensed pharmacist". In 16 hospitals this supervision is the responsibility of the chief resident physician, and in 21 hospitals the responsibility of the superintendent of nurses. One hospital reported that prescriptions were filled at another hospital.

In the provinces east of Ontario, 53 hospitals without a pharmacist vary in bed capacity from 50 to 1,000 beds. Of these 5 reported that prescriptions were filled at local pharmacies and 3 at another hospital. In 6 hospitals "the pharmacist is required to be in attendance at all times", and in 12 "most of the time". In spite of the denial of the employment of a hospital pharmacist, one hospital in the 500 to 1,000 bed classification reported that "the responsibility for supervision and distribution of all medicaments is vested in a licensed pharmacist". Physicians assumed this responsibility in 12 hospitals, the superintendent of nurses in 12 hospitals, a registered nurse in 13 hospitals and the hospital superintendent or assistant superintendent in 2 others.

In the provinces west of Ontario, 54 hospitals reported. Of these 30 have 50-99 beds, and 2 over 1,000 beds. A total of 9 hospitals out of these 54 have their prescriptions filled at local pharmacies or at another hospital. Nurses, resident physicians, and a few administrators assume this responsibility in other hospitals.

* *The authors are respectively professor of pharmacy administration, and special lecturer in hospital pharmacy administration.*

Hospital Pharmacy Practice in the Various Provinces

A larger proportion of hospitals of 50 beds or more in the western provinces employ one or more hospital pharmacists (Table I). Saskatchewan leads with 41.0 per cent, followed by Manitoba with 35.7 per cent and Alberta with 35.4 per cent.

Salaries for full-time men, ranging from $7,000-$7,999 a year, are reported in Ontario and British Columbia. The lowest salaries received by men for full-time employment, $2,000-$2,999 a year, are indicated in Newfoundland and Nova Scotia. The annual salary for full-time women in Ontario and Quebec is higher than in other provinces where two women receive $5,000 to $6,999 a year. Many more women than men receive between $2,000 and $2,999 a year and one pharmacist in Nova Scotia receives below $2,000 a year.

Pharmacists in Prince Edward Island work 56 hours per week as compared with 35 hours a week for pharmacists in Newfoundland. In British Columbia, Manitoba, Ontario and Saskatchewan, pharmacists work less than 44 hours a week, the average for all the provinces. The number of hours per week the Pharmacy Department is open is highest in Quebec, 61 hours as compared with 40 hours per week in Newfoundland. Alberta, New Brunswick, Prince Ed-

Table XIII

Ontario Hospitals Not Employing A Pharmacist

Bed Capacity

	50 to 99		100 to 149		150 to 199		200 to 499		500 to 1,000		Over 1,000 beds	
Number of hospitals in Canadian Hospital Directory	43		—51—				35		—31—			
No. of hospitals giving information	22		5		5		6		5		5	
	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
Is the pharmacist required to be in attendance at all times?	..	17	..	3	..	5	1	3	1	1	..	2
Most of the time?	3	13	1	2	2	2	2	2	..	1	1	1
Is the responsibility for supervision over and distribution of all medicaments vested in a licensed Pharmacist?	..	19	..	3	..	2	..	5	..	3	1	3
—Chief Resident Physician?	3	9	..	2	2	..	4	1	4	1	3	.
—Superintendent of Nurses?	15	..	4	1	2	1	..	2	..	2	..	.
Other												
Registered Nurse	..	..	..	..	..	..	1	..	1	..	1	..
Superintendent	2	..	..	..	..	..	1	..	..	..	..	..
Assistant Superintendent	2	..	..	..	..	..	..	..	..	..	1	..
Administrator	2	..	..	..	..	..	..	..	..	..	..	..
Rx filled at another hospital	..	..	..	..	1	..	..	..	..	..	..	..
Rx filled at local pharmacies	3	..	..	..	..	..	..	..	..	..	..	..

Table XIV

East of Ontario

Hospitals Not Employing A Pharmacist

Bed Capacity	50 to 99		100 to 149		150 to 199		200 to 499		500 to 1,000		Over 1,000 beds	
Number of hospitals in Canadian Hospital Directory	51		—74—				64		—27—			
No. of hospitals giving information	10		19		9		9		5		1	
	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
Is the pharmacist required to be in attendance at all times?	..	2	..	7	4	..	2	1	..	3	..	..
Most of the time?	..	2	4	4	5	..	..	1	3	..	..	..
Is the responsibility for supervision over and distribution of all medicaments vested in a licensed Pharmacist?	..	3	..	9	..	6	..	5	1	2	..	..
—Chief Resident Physician?	..	..	5	..	3	..	2	..	1	..	1	..
—Superintendent of Nurses?	2	..	5	..	5	..	..	..	..	..	..	..
Other												
Registered Nurse	3	..	4	..	2	..	2	..	2	..	..	..
Superintendent	1	..	..	..	..	..	..	..	..	..	..	..
Assistant Superintendent	..	..	..	..	..	..	..	..	..	..	1	..
Administrator	..	..	..	..	..	..	..	..	..	..	..	..
Rx filled at another hospital	..	..	2	..	..	..	1	..	..	..	..	..
Rx filled at local pharmacies	2	..	1	..	..	..	1	..	1	..	..	..

Table XV

West of Ontario

Hospitals Not Employing A Pharmacist

Bed Capacity	50 to 99		100 to 149		150 to 199		200 to 499		500 to 1,000		Over 1,000 beds	
Number of hospitals in Canadian Hospital Directory	64		—49—				33		—24—			
No. of hospitals giving information	30		11		6		3		2		2	
	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
Is the pharmacist required to be in attendance at all times?	1	14	1	2	..	2	..	2	..	..	..	2
Most of the time?	2	14	2	3	3	1	..	1	..	..	..	..
Is the responsibility for supervision over and distribution of all medicaments vested in a licensed Pharmacist?	1	17	..	5	1	2	..	..	..	..	..	..
—Chief Resident Physician?	2	..	1	..	1	..	2	..	..	..	1	..
—Superintendent of Nurses?	17	..	6	..	..	..	..	..	..	..	..	..
Other												
Registered Nurse	3	..	..	..	1	..	1	..	..	..	..	..
Superintendent	..	..	..	..	3	..	..	..	..	..	..	..
Assistant Superintendent	..	..	..	..	..	..	..	..	..	..	..	..
Administrator	..	1	..	..	..	..	..	..	..	..	..	..
Rx filled at another hospital	1	..	1	..	..	..	..	..	1	..	..	..
Rx filled at local pharmacies	5	..	1	..	..	..	..	..	..	..	..	..

ward Island, Quebec and Saskatchewan all reported more than 53 hours per week, the average for all the provinces. British Columbia, Manitoba, Newfoundland, Nova Scotia and Ontario average less than 53 hours per week.

The total work load of prescriptions and ward orders per hour varies from 27.0 in Quebec to 9.0 in Nova Scotia. Quebec, Ontario and British Columbia hospitals exceed the total average work load of 16.5 as reported in this survey. Hospitals in Quebec, Ontario and Alberta reported that they filled more prescriptions and ward orders per month than the other provinces and averaged more than the 5,271 total for all provinces.

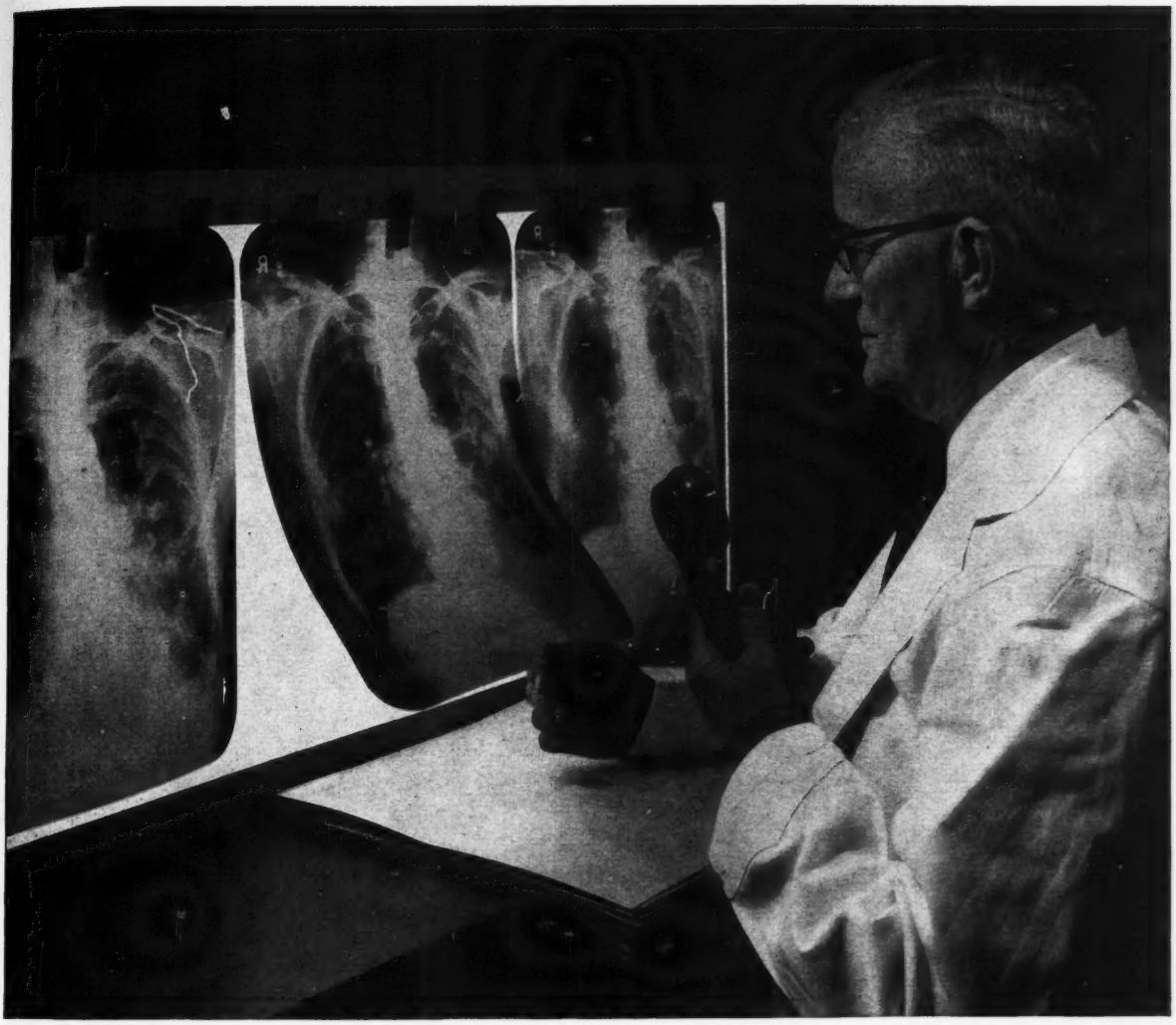
In addition to their regular duties, some pharmacists in all provinces, with the exception of Newfoundland, act as purchasing agent for the Pharmacy and give lectures to nurses and medical students. Some pharmacists in British Columbia, Manitoba, Nova Scotia, Ontario, Quebec and Saskatchewan serve as purchasing agents for the hospital. In Nova Scotia, two pharmacists do clerical or secretarial work and one serves as an assistant administrator of the hospital. In Ontario, one pharmacist is also the administrator of the hospital.

Conclusions

In this survey of hospital pharmacy practice in Canada, 349 replies were received from the 673 hospitals of 50 beds or more in the ten Canadian Provinces and the Yukon and North West Territories — a return of 51.8 per cent. Only 199 or 29.5 per cent of these hospitals employ a pharmacist. Replies were received from 168 of these 199 hospitals, giving a return of 84.4 per cent from these hospitals which do employ a pharmacist.

The survey showed that more men than women are engaged in the practice of hospital pharmacy in Canada, 179 as compared with 141 respectively, making a total of 320 pharmacists. Ninety-two of the 168 hospitals, or 54.8 per cent, employ only one pharmacist and 36 hospitals or 21.4 per cent have two pharmacists on their staff. The largest number reported in any one hospital was 9 pharmacists.

If workloads in the 168 Canadian hospitals approximate those in the standard staffing pattern and are based on similar factors, the number of personnel in all bed groups is below the figure recommended. The shortage is particularly acute in the 400-499 bed group of short-term hospitals, where only one full-time pharmacist for every 247.3 beds was reported. Workloads of 20.1 to 27.3 prescriptions and ward orders per pharmacist per hour in



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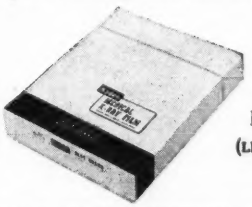

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Pharmacy . . . . **TABLE XVI**

	Alberta	British Columbia	Manitoba	New Brunswick	Newfoundland	Nova Scotia	Ontario	Prince Edward Island	Quebec	Saskatchewan	Total
Distribution of Hospitals											
Employing one or more pharmacists	16	17	9	7	1	12	62	1	28	15	168
Number of Pharmacists											
Men, full-time	11	30	8	6	2	8	71		21	15	172
Men, part-time	4	1					1		1		7
Women, full-time	11	5	6	3		11	54	1	38	10	139
Women, part-time		1					1				2
Total	26	37	14	9	2	19	127	1	60	25	320
Salaries											
Men											
$7,000 - $7,999		1					2				3
$6,000 - $6,999		1					2		1		4
$5,000 - $5,999		3				1	13		3		20
$4,000 - $4,999	8	16	3	2		3	30		2	5	69
$3,000 - $3,999	3	7	5	4	1	2	20		13	9	64
$2,000 - $2,999					1	2				1	4
Below $2,000	4 pt.	1 pt.							1		6
Not Given		2					5		2		9
Women											
$6,000 - $6,999									1		1
$5,000 - $5,999							1		1		2
$4,000 - $4,999	1	1		1			22		6	3	34
$3,000 - $,3999	9	4	4	1		3	18		19	7	65
$2,000 - $2,999		1	1			6	2	1	1		12
Below $2,000						1					1
Sisters			1	1		1	11		10		24
Not Given	1						1				2
Other Benefits											
Room	1					2	4	1	6		14
Uniforms	10	19	2	3		4	51	1	34	9	133
Laundry (uniforms)	12	16		3		2	37	1	21	7	89
1 or more meals a day	8	1			1	2	9	1	32	1	55
Blue Cross	11			2		1	26		4		44
Average no. of hours per pharmacist per week	47	40	43	47	35	50	43	56	50	43	44
Average no. of hours pharmacy open per week	56	47	47	59	40	51	52	56	61	58	53
Average Work Load per Pharmacist											
Average no. of prescriptions per hour	6.7	4.9	8.7	9.3		6.8	14.5	7.1	14.4	5.6	8.3
Average no. of ward orders per hour	11.3	4.8	4.4	5.9		2.2	8.1		12.6	6.5	8.2
Total	18.0	9.7	13.1	15.2		9.0	22.6	7.1	27.0	12.1	16.5
Other Duties											
Purchasing Agent for the Pharmacy	10	11	5	6		8	51	1	21	9	122
Purchasing Agent for the Hospital		2	1			3	4		3	2	15
Lectures to Nurses and Medical Students	7	3	1	2		6	14	1	10	4	48
Clerical or secretarial work						2					2
On call nights, holidays, Sundays	8	11	6	4	1	10	42	1	18	8	109
Hospital Administrator							1				1
Assistant Administrator						1					1
Average no. of prescriptions per hospital per month	2,711	3,018	2,644	2,560		1,943	2,771	1,740	6,007	1,935	3,018
Average no. of ward orders per hospital per month	3,606	1,924	1,156	1,670		812	2,690		3,899	1,573	2,253
Total	6,318	4,942	3,800	4,230		2,755	5,461	1,740	9,906	3,508	5,271

(text continued on page 66)

(Text continued on page 66)

Nurses' Lounge of Nurses' Residence, Calgary General Hospital showing attractive ceiling installation of Acousti-Celotex Celotone* Incombustible Sound Conditioning Tile.

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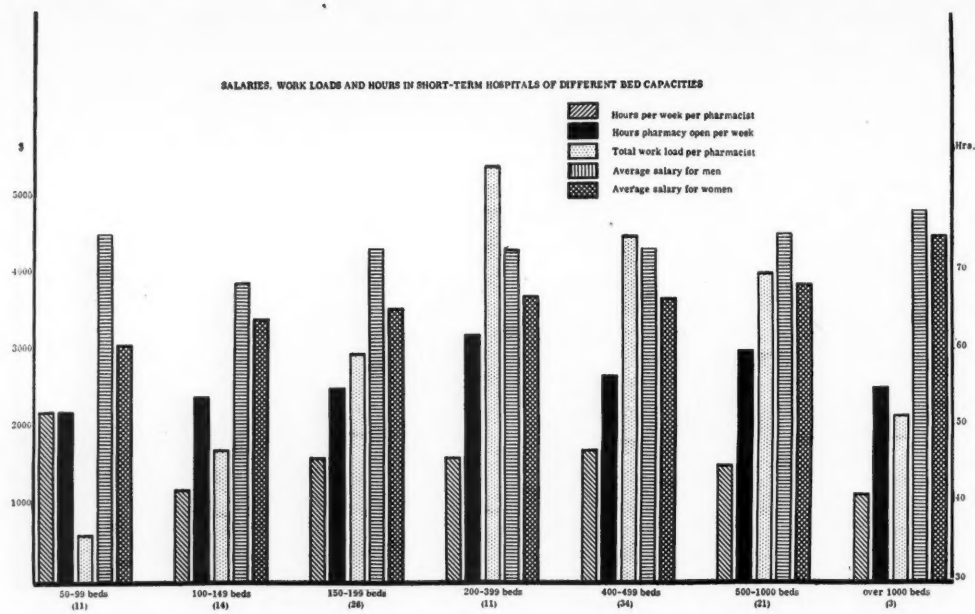

Fig. IV.

short-term hospitals from 200 to 1,000 beds appear too high to be in keeping with accepted standards of efficiency, economy and safety.

The average salary for women pharmacists is well below that received by male pharmacists in all types of hospitals with the exception of the 22 long-term hospitals, where the salary for women slightly exceeds the salary received by men. Annual salaries for full-time pharmacists range from $2,000 to $7,999, while those for female pharmacists do not exceed $5,999 and one hospital reported an annual salary of below $2,000. The highest average salary, $5,100 per year, was received by pharmacists in hospitals owned and operated by the Department of National Defence. In most short-term hospitals, the salary is not proportional to the workload or hours reported. Peak workloads per hour are observed in hospitals of 200 to 399 bed capacity, while the shortest working hours and highest salaries were reported by hospitals of over 1,000 beds capacity.

In the reports from the 155 hospitals which do not employ a pharmacist the responsibility for supervision and distribution of all medicaments is vested as follows:

Chief resident physician	28
Superintendent of Nurses	56
Registered Nurse	21
Assistant Superintendent	4
Administrator	2

This indicates that some type of pharmaceutical service exists but implies that unlicensed and unqualified personnel may be involved in this responsibility in many instances.

In the 8 hospitals of 1,000 beds and over, surely the full-time services of one hospital pharmacist or more should be considered essential for both service and economy.

A large proportion of hospitals of 50 beds or more in the Western provinces employ one or more hospital pharmacists. A wide variation in hours of service, workloads, benefits and salaries was reported in each province. Lectures to nurses and medical students and hospital purchasing were most frequently included as other duties of the hospital pharmacist.

If only 29.5 per cent of the 673 hospitals in Canada (of 50 beds or over) employ a pharmacist, the need to train graduates for this branch of the profession is evident. The statistics reported on workloads, hours of service and salaries in civilian hospitals are discouraging as far as recruitment of students for hospital pharmacy is concerned. At the time of this survey the most attractive positions in the field are those in hospitals owned and operated by the Department of National Defence. Since 1,000 of the total 1,398 hospitals in Canada have less than 100 beds, and since 1,009 of these 1,398 hospitals fall in the category of public ownership, *e.g.* lay corporations, religious orders or the Red Cross et cetera, greater emphasis should be given to hospital pharmacy practice in smaller hospitals and every effort should be made to inprove the working conditions and salaries in our public general hospitals to make these positions more attractive to our candidates. ●

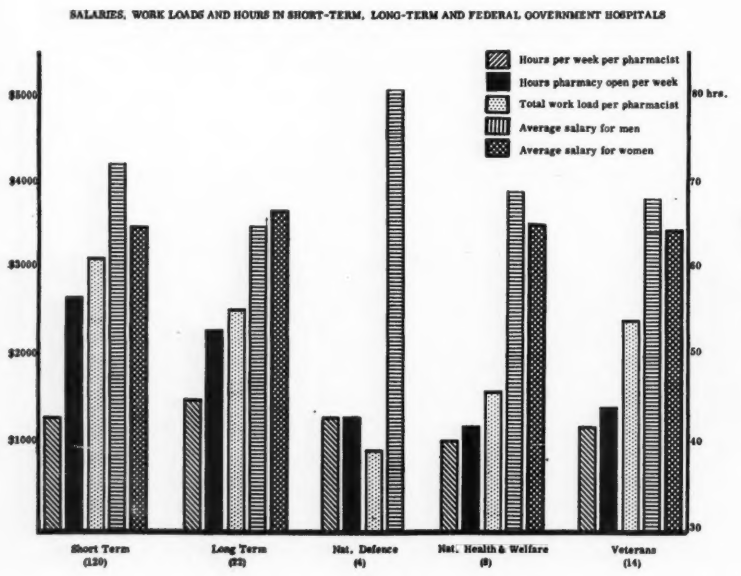

Fig. V.

For Trustees Only:

Focusing the Administrative Eye

Mrs. Charles McLean,
President,
Ontario Hospital Association
Toronto, Ont.

LET US consider that very stalwart citizen in the community — your hospital administrator. First, to acquaint you with the tremendous responsibility which rests upon this one person in your midst, and, secondly, to pay tribute to the character and accomplishments of this busy individual.

Administration of a hospital is not an end in itself, but only a means to the end that the hospital may give to its patients, as well as to its medical staff, a consistently high quality of service. Thus the administrator must not only control management detail, but must also act as liaison officer between the hospital board, the medical staff, and all other groups which function within the total organization. This requires interpreting to each group the needs and problems of the other, and the elimination of misunderstandings which may arise between them.

Policies of operation are decided by the governing board, but good hospital care cannot be created by legislation alone. There are two distinct parts to the dispensing of good hospital care. The first part depends, primarily, upon the training experience and judgement of members of the medical staff. And yet each physician represents a very definite entity, with special personality characteristics. The wise administrator will not attempt to change this individualism, but must recognize it, accept it, and find ways of working with it. Thus hospital administration becomes a perpetual exercise in human relations.

The second part of providing good hospital care requires that the medical staff and all departments must be supplied with the manpower, the materials, and the equipment which are necessary for work to be carried out effectively. This again requires administrative and executive skill, and the coordination of all departments and services in the hospital to achieve success.

Administration, therefore, is not a game of solitaire, where the superintendent moves cards, pushes buttons, or juggles statistics, hoping to beat the complex game of operation. Such solitary occupation would soon be snowed under by the avalanche of reports, requests, requirements and regulations which land in unceasing flow upon the executive desk.

To co-ordinate all the activities and services of the hospital, to keep in constant review its equipment or expansion needs, to soothe the sometimes "savage breast" of employee or patient, striving always to operate with the limitations of the hospital's precarious budget, requires the service of a person of diversified knowledge and ability.

When the attractive young lady on the popular TV "big question" show presses the button on the huge automatic machine for the chosen category, its mechanical brain is set in motion to produce the contestant's initial questions. There is a scurry of activity as questions are thrown out from the various compartments. Unfortunately, the big machine does not give the answers. Those remain for one worry-laden person — the contestant — to produce.

I have often thought that a hospital superintendent must sometimes feel like the contestant in the case, as questions flow from all departments of the hospital to the administrative desk. Certainly the questions, and the problems they produce, are as varied as they are complex, and present a formidable challenge to the administrator who must come up with the right answers.

Who, for instance, must be "on call" twenty-four hours of every day for emergency consultation; who must arrange for an extra bed when all regular beds are filled; who must confer with the director of nursing and have intimate knowledge of the service she directs; who must keep an eye on the cost of food and coal which the dietitian or engineer requires; who must know the best — and sometimes the quickest — source for medical supplies and equipment; who must plan for major hospital maintenance, such as painting or renewing furnishings and fit these needs into the routine activities of service with a minimum of interruption; who must be able not only to understand the hospital's financial statement, but know the many factors that combine to produce it? Who, indeed, but the administrator!

Mrs. Charles McLean

Thus an administrator must, among other things, serve as purchasing agent, lawyer, confidential clerk, accountant, messenger boy, public relations officer, and diplomat; must know regulations and be able to find authority or official guidance for any course of action proposed or thrust upon the hospital; must be an expert in solving the problems of human relations, both within and outside the hospital, and yet preserve the dignity and authority of executive management.

Adding fire or spice to the administrator's task are safety campaigns, building projects, community endeavours, educational programs for student nurses and medical education programs, for interns and residents. Co-operation with various levels of government and with social agencies in the community all have a claim on the administrator's knowledge and time. Despite all the varying demands, the administrative eye must always keep focused on the patient, who represents the hub of this revolving wheel of hospital service.

All these requirements add up to a very special individual — one who must be honest, loyal, patient, possessed with enthusiasm and a sense of humor, and, as Ray E. Brown, president of the American Hospital Association, puts it, must "love his fellow man if he is going to be allowed to run loose in society and not be avoided by his secretary".

I can assure you that few people "avoid" the hospital administrator. On the contrary, everyone from board member to orderly, from physician to file clerk, seek knowledge and strength and help in solving the problems that beset them. •

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Certification of

Hospital Administrators

William C. Hibbert,
Superintendent,
Wadena Union Hospital,
Wadena, Sask.

AT THE last meeting of the Saskatchewan Hospital Association, one of the main topics of discussion was a system of certification for certain hospital personnel. In regard to this matter, the following resolution was passed:

WHEREAS the hospitals of the Province of Saskatchewan are spending over fifteen million dollars of public monies:

AND WHEREAS many smaller hospitals have little or no management where only part-time accounting and management is engaged:

THEREFORE BE IT RESOLVED that the Saskatchewan Hospital Association in consultation with the Department of Public Health, Hospital Standards and Administration Division, arrange to have a study made with a view to implementing a system of certification for hospital secretaries, secretary-managers and superintendents, similar to that used by the Department of Municipal Affairs and the Saskatchewan association of rural municipalities.

In compliance with these instructions, a committee was appointed, with members from the Department of Public Health and the Saskatchewan Hospital Association.

The departmental committee members are H. L. Livergant, P. E. Hunt, D. Krawchuck, and Dr. I. Gogan as an advisor. The Saskatchewan Hospital Association committee members appointed are: N. Hall, A. W. Holtby, E. V. Walshaw and W. C. Hibbert. Mr. Hibbert was selected chairman of this committee and H. L. Livergant secretary.

Our committee, on examining the resolution, could see no specific direction indicated, only a broad outline of a study which was to be made. If direction had been given to the scope of our studies we could have, with fewer meetings, made our study and drafted our recommendations. Therefore, the committee decided that every plan in operation elsewhere in Canada and the U.S.A. would have to be thoroughly examined for ideas which could be adapted to our needs in Saskatchewan. Not only would we have to present some possible solution to this Convention, but it must also meet with the approval of the Department of Public Health in the province.

We then set up aims and objects for guidance, conforming to the requirements of this province, with its diversity of hospital capacity. How to accomplish these objects *i.e.*, a system of certification for hospital administrators (persons delegated by hospital boards for the day-to-day operation of the hospitals).

With 80 per cent of the hospitals in a category of 50 beds or less, and the majority of these under 25 beds, it was apparent that the existing courses in hospital administration (*i.e.* graduate courses offered by various universities) were above the requirements of these small hospitals. Therefore a training program of some sort must be made available to prospective administrators if they are expected to be certified. It was not intended to supplant the existing courses. The ideal would be, of course, the Canadian Hospital Association extension course certificate as a minimum requirement. This, however, was not practical if a program of certification was to be instituted within the near future because only a limited number can be so trained.

After examining all programs it was agreed that the best method would be to follow a pattern somewhat similar to that used in municipal affairs. Modifications to meet different needs were examined, and we propose to present our conception of the principles by which this could be effected, and rules and regulations that would govern these principles.

Problems to be considered were:

(a) Financing such a program. The Saskatchewan Hospital Association had no such funds available. The hospital administrators were not organized nor was there any immediate prospect that they would form an association. Who would benefit most from such a program? The S.H.S.P. hospital plan and its resources. Therefore we felt that the province should bear the cost if this was possible.

(b) Who should direct this program? Adequate controls must be set up to safeguard the administrators, as well as those financing the program.

(c) Should there be various types or grades of certificates? This need was evident because of the range of sizes of hospitals in the province. We could not obtain legislation for only some of our administrators.

(d) Who and how many to be trained? As shown before, the need was only for the really small hospital and these are in the majority at present.

(e) Is certification necessary and should it be mandatory? To get good management, certification was considered to be necessary and to ensure certification it should be mandatory.

(f) Who should issue certificates?

(g) What about those already in the hospital field?

Something that would meet with the approval of the administrators already appointed was necessary to ensure their co-operation.

The word "licensing" was used to a great extent but was objected to by many committee members. Therefore this term was dropped. At the present time Dr. Gogan is on tour in the U.S.A., and on his agenda is "study of the licensing of hospital administrators in Minnesota and Indiana".

With the close co-operation of the Department of Public Health, a draft of suitable legislation was made, together with rules and regulations made under these proposed amendments to the Hospital Standards Act. This is only the thinking of the Committee put into possible legislation, and does not mean that it will meet with the full appproval of the Department of Public Health, the cabinet, or the provincial legislature. It covers only the principle as recommended by the committee.

There follows the draft legislation, with rules and regulations.

Draft

Legislation required to provide for the training and certification of hospital administrators.

By amendments to the Hospital Standards Act in the following wording:

1. In the following sections, the expression "administrator" or "chief executive officer" means that superintendent, administrator, matron, secretary-manager, or other officer to whom the board has delegated responsibility for

From a paper presented at the annual convention of the Saskatchewan Hospital Association, in 1955.

the day-to-day management of hospital activities.

2. The Lieutenant Governor in Council may appoint a board of examiners to conduct examinations of administrators and of persons who decide to qualify as administrators of hospitals and may make regulations:

(a) prescribing the subjects of examination;

(b) governing the method of conducting examinations;

(c) defining the powers and duties of the board of examiners;

(d) governing the issue of certificates of qualification;

(e) prescribing the qualifications to be held by the administrator of any hospital or any class or classes of hospitals; and

(f) generally for carrying out the purposes of this section.

3. The Minister may:

(a) classify hospitals for the purposes of this section and the regulations;

(b) provide a training course of studies for all persons who wish to become qualified hospital administrators; and

(c) issue certificates of qualification to persons qualified to be hospital administrators upon the basis prescribed by the Lieutenant Governor in Council.

Draft of regulations which could be made if legislation were passed to provide for the examination and certification of hospital administrators.

1. (a) For the purposes of these regulations, there shall be a board, to be known as the Board of Examiners, consisting of three persons appointed by the Lieutenent Governor in Council.

(b) One person so appointed shall be recommended by the Saskatchewan Hospital Association; another shall be an official of the Department of Public Health; while the third shall be the person agreed upon between the Department of Public Health and the Saskatchewan Hospital Association.

(c) The members of the Board of Examiners shall be paid such per diem allowance and travelling expenses as may be determined by the Lieutenant Governor in Council.

2. The duties of the Board of Examiners shall consist of:

(a) preparation of examination papers relating to the subjects upon which candidates may be examined;

(b) fixing the dates of examinations and naming the places in the province where such examinations shall be held;

(c) appointment of presiding examiners and prescribing their duties;

(d) examination of written answer papers of candidates and grading such answers;

(e) advising unsuccessful candidates of the marks secured on each subject written upon;

(f) reviewing the applications for certificates of qualification as hereinafter provided;

(g) such other duties as may be necessary to properly carry out these regulations.

3. A secretary of the Board of Examiners shall be appointed, whose duties shall consist of:

(a) receiving applications from persons who desire to be examined in the subjects hereinafter referred to, and affixing to each a distinguishing number which shall be the number by which the written answer papers of a candidate shall be identified;

(b) maintaining a register of candidates for examination, showing the marks obtained thereat bv each;

(c) advising each candidate for examination of the number by which the written answer papers submitted by him shall be distinguished;

(d) such other duties as may be imposed by the Board of Examiners.

4. The secretary shall not divulge to the members of the Board of Examiners any information bv which such members may gain knowledge of the identity of a candidate until the examination and grading of all papers has been completed.

5. Any person, twenty-one vears of age or over, who has had at least six months service in a hospital or such other experience as the Board may deem to be sufficient, and who has completed grade XI or has academic standing equivalent thereto, may make application in such form as may be prescribed by the Board, to be examined in the subject matter hereinafter referred to:

Provided that the board may, in its discretion, waive the portion of this regulation dealing with academic standing or may accept applications without proof of academic standing.

Provided further, that the Board may, in its discretion, accept the application of any person who has not attained twenty-one years of age prior to the date set for the examination in respect of which the application is made, but in the event such a person is successful at such examination, a certificate of qualification shall not be issued to him until he attains the said age.

6. All applications shall be in the hands of the secretary at least thirty days prior to the date set for the examination.

7. Each application shall be accompanied by an examination fee according to the following schedule:

Ten dollars ($10,00) if three subjects are to be written;

Seven dollars and fifty cents ($7.-50) if two subjects are to be written;

Five dollars ($5.00) if one subject is to be written.

8. A candidate for examination may make application to the Board of Examiners to be exempted from writing upon any or all subjects of examination and the Board may, in its discretion, allow the exemption if satisfied that the candidate is fully qualified in the particular subjects in respect of which exemption is requested.

9. Subject to the preceding clause, all candidates for examination shall be examined in the following subjects:

(1) hospital organization and management,

(2) accounting and statistics,

(3) law and secretarial responsibilities.

10. The minister may provide a training course of studies, on the subjects mentioned in section 9 of these regulations, to all persons interested in writing examinations upon such subjects.

11. Examinations shall be held annually or at more frequent intervals if deemed necessary by the Board. Mountain standard time shall apply to all examinations. Examinations in various parts of the province, as may be selected by the Board, shall be held on the same day and hour.

12. All examinations shall be written on paper supplied by the board.

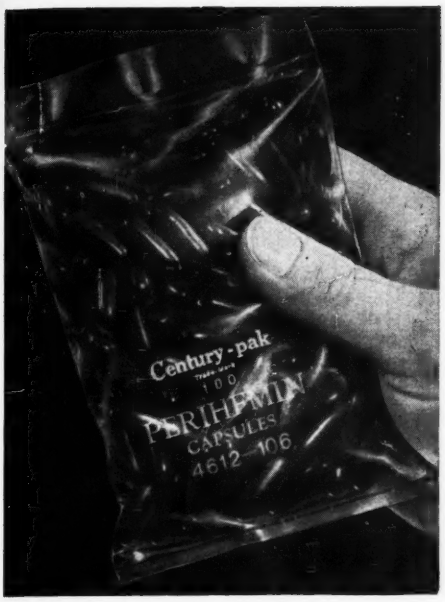
13. A supply of stationery, together with a sufficient number of examination papers in sealed envelopes, shall be sent to each presiding examiner. Examination papers shall be sent by registered mail.

14. At the appointed place for holding the examination, the presiding examiner shall, ten minutes before the time of commencement with respect to each subject, supply each candidate with writing paper and shall read the rules governing candidates while engaged in writing the examination. Upon being satisfied that the candidates fully understand the rules, he shall, in the presence of the candidates, break the seal of the packet containing the examination papers of the subject assigned and shall deliver to each candidate a copy of such examination paper.

15. The presiding examiner shall collect all written answers of the candidates upon the expiry of the period allowed and shall forward or deliver same to the Board of Examiners.

16. A candidate must obtain 60 per

(Concluded on page 76)



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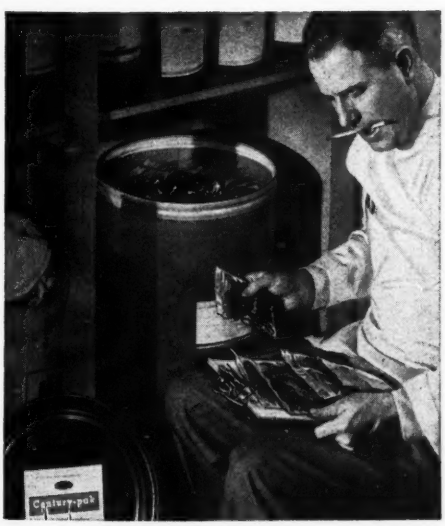

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(Concluded from page 74)

cent of the total number of marks allotted to each subject in order to obtain successful standing at an examination.

17. An unsuccessful candidate may request the board to re-examine his answer papers by making application within 60 days after results are announced and enclosing a fee of one dollar ($1.00) for each paper to be examined. The secretary to the Board shall, not less than ten days before the date on which the board meets to re-examine such papers, notify each such candidate of the time and place at which the meeting will be held and any such candidate may attend in person before the board at that meeting and the board may, if satisfied of his qualifications, grant a pass in the papers reviewed.

18. Supplementals may be granted to a candidate who obtains the required percentage of marks in respect of any subject written upon but fails on the other subjects, or either of them. Supplementals shall not be granted in any subject unless the candidate writes on all subjects or on all subjects on which, having previously written, he failed to secure pass marks.

19. A candidate securing pass marks in any subject shall not be required to write upon that subject thereafter unless during a period of five years following the date on which he secured such pass marks, or such additional period or periods as the Board of Examiners may allow, he fails to pass in the remaining subject or subjects.

20. Written answer papers shall be retained for six months after results are announced and if no longer required for the purposes of re-examination, shall then be destroyed.

21. The following rules shall apply to the conduct of presiding examiners and candidates:

(a) No conversation, correspondence or signs shall be exchanged between candidates after receiving examination papers.

(b) No candidate shall request from the presiding examiner, nor shall the latter offer to any candidate, information which may assist a candidate in the examination.

(c) Each sheet of paper shall be headed with the subject matter, number of pages, and the distinguishing number assigned to each candidate. No other mark by which the identity of a candidate may be learned shall be placed upon the answer papers.

(d) Upon completion of the examination or upon expiry of the time allotted thereto, each candidate shall insert in an envelope supplied for the purpose all answer papers written by him. He shall inscribe on such envelope the subject matter, the date of examination and his distinguishing number and, after sealing same, shall deliver it to the presiding examiner and forthwith leave the room in which the examination is held.

(e) Should any candidate leave the room before he has completed his examination paper, he shall deliver same to the presiding examiner as required in clause (d) and shall forfeit his right to complete his answers to such examination.

22. (1) A person applying for a certificate of qualification or a provisional certificate of qualification shall forward his application to the minister together with an application fee for five dollars ($5.00). Such fee shall be remitted to the applicant if the certificate is not granted.

(2) The minister shall therupon forward such application to the Board of Examiners for its recommendation.

(3) The Board's recommendation shall assist the minister in deciding whether a certificate should be issued.

23. The minister may issue certificates of qualification upon the following basis:

(1) a certificate of qualification, designated as Class A, to a person who:

(a) has successfully completed a post-graduate course in hospital administration at a recognised university;

(b) has been employed as administrator of a hospital in Saskatchewan classified by the minister as a base hospital, for at least three years during the five-year period immediately preceding the first day of January, 1958; or

(c) has demonstrated outstanding ability and qualifications.

(2) A certificate of qualification, designated as Class B, to a person who:

(a) has successfully completed a course in hospital organization and management provided by the Canadian Hospital Association, and has completed two years continuous service in a recognized hospital;

(b) has been employed as administrator of a hospital in Saskatchewan classified by the minister as a regional hospital for at least three years during the five-year period immediately preceding the first day of January, 1958;

(c) has demonstrated suitable qualifications.

(3) A certificate of qualification, designated as Class C, to a person who:

(a) has completed the training course of studies provided by the minister and passed the examinations held by the Board of Examiners pursuant to these regulations;

(b) has been employed full time as administrator of a hospital in Saskatchewan classified by the minister as a district hospital or a community hospital for at least three years during the five-year period immediately preceding the first day of January, 1958;

(c) has been employed part time as administrator of a hospital in Saskatchewan designated by the minister as being a district hospital or a community hospital for at least five years during the ten-year period immediately preceding the first day of January, 1958; or

(d) has suitable qualifications.

24. The minister may issue a provisional certificate of qualification to a person who has commenced taking the training course of studies provided by the minister under these regulations. The validitly of such provisional certificate shal terminate on a date fixed by the minister.

25. On and after the first day of January,

(1) a hospital classified by the minister as being a base hospital, shall employ as administrator only a person who is in possession of a certificate of qualification designated as Class A.

(2) a hospital classified by the minister as being a regional hospital shall employ as administrator only a person who is in possession of a certificate of qualification designated as Class A or as Class B.

(3) a hospital classified by the minister as being a district hospital shall employ as administrator only a person who is in possession of a certificate of qualification designated as Class, A, Class B or Class C, or who is in possession of a valid and subsisting provisional certificate of qualification.

26. The minister shall have power to cancel any certificate upon proof of dishonesty or gross negligence in the discharge of an administrator's duties, or for any other justifiable cause.

It's the Spirit that Counts!

"Received a letter from Uncle Willy today. He's still in hospital."

"What did he say about the brandied cherries we sent him on his birthday to cheer his convalescence?"

"He said he was afraid that he wasn't strong enough to eat the fruit, but he appreciated the spirit in which it was sent!"

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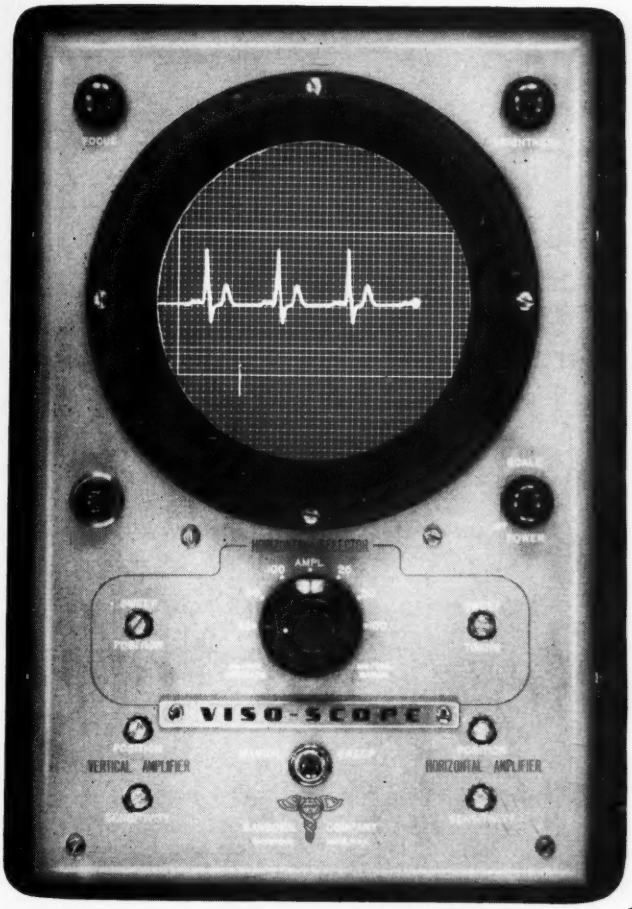

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- **direct connection of leads from patient to unit**
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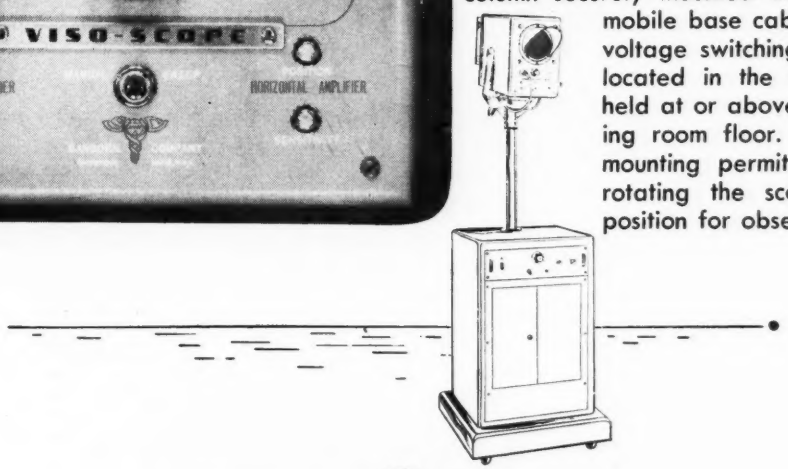
The viewing unit is supported by a steel column securely mounted in a weighted mobile base cabinet. All high voltage switching circuits are located in the viewing unit, held at or above the operating room floor. Swivel yoke mounting permits tilting and rotating the scope to best position for observation.



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The Education of Food Handlers

(The following is an except from an article entitled "The Education of Food Handlers", by C. E. Hornady, C.S.I. (C), Local Board of Health, Edmonton, Alta., in the Canadian Journal of Public Health, July 1956.)

In training food handlers, some of the best tools are films and film strips. In all the provinces, provincial departments of health maintain film libraries which include films and film strips on food sanitation. We have had difficulty in locating suitable films to present with the introductory part of a short course.

"Preventing the spread of disease", "Eating out" (reel 2), and "Behind the menu" are good, but the first two mentioned are rather old films. Three excellent film strips have been produced by the United States Public Health Service, namely, "Germs take pot luck", "In hot water" and "Safe food for good health". Our Alberta health education division has a copy of each of these and doubtless other provinces have also. We have prepared our own commentaries for these, although I believe there are original scripts and records accompanying them. Each of our commentaries takes approximately 30 minutes.

The film strip "Germs take pot luck" and the film "Hash slinging to food handling" make an excellent combination for the session on bacteriology.

The film strip "In hot water" deals mainly with dishwashing and therefore is very good to use for this topic. Good films to use in developing this important branch of food handling are "Dishwasher named Red", and "Safe Service". The latter emphasizes the advantage of paper service and illustrates proper methods to be followed.

The best aids we have found, so far, in the class in personal hygiene are the film strip "Watch your health", and the film "One girl to another." As part of the latter film is concerned with personal details, the film should be presented to women only, preferably by a public health nurse. The film strip "Safe food for good health" and the film "Best foods in town" are suitable for the concluding session.

There is also a very good film entitled "Biology of domestic flies" and there are others on rats, and proper garbage disposal.

"Watch your Health" is one in a series of four film strips, and can be purchased from the National Film Board at approximately $1.50 per film strip. In connection with the use of film strips, I would suggest that you procure a microphone to attach to your sound projector. There is a certain psychological effect derived from a commentary coming from the screen instead of from the back of the room. To provide special instruction for proprietors or supervisors on machine dishwashing and proper utensil storing and handling, an excellent combination is the film "Dishwashing dividends", and the film strip "Handling without hands". This latter is produced by the Metropolitan Wire Company.

Scurvy Still Exists

Although the cure and prevention of scurvy has been known for more than 150 years, scurvy in infants and children still occurs in spite of our present day fund of knowledge. Scurvy is a nutritional disease caused by a lack of Vitamin C in the diet. It is not a contagious disease and can be prevented. The infant with scurvy becomes pale, anaemic, cross and irritable. The leg joints may become swollen and tender and the baby will cry when handled or moved. There also may be bleeding from the infant's gums. Its prevention requires the regular inclusion of Vitamin C in the diet.

Book Reviews

LAW RELATING TO HOSPITALS AND KINDRED INSTITUTIONS. By S. R. Speller, LL.B. Third edition. Pp. 649. Price £3 10s. Published by H. K. Lewis & Co. Ltd., London, England, 1956.

This is the third edition of a well-known book, first published in 1947. In the present edition the chapter on injuries to patients has been completely rearranged and rewritten because the extent of the vicarious liability of hospital authorities for such injuries has been much clarified by cases decided since the second edition was published. Chapters on the constitution, functions, and powers of hospital authorities under the National Health Services Acts, 1946 to 1952, have also been rearranged.

Chapter headings are as follows: hospitals — definitions and classifications; state hospitals; hospitals administered under the National Health Service Act, 1946; voluntary hospital authorities; charitable trustees and charity commissioners; provision of pay beds; consents to operation and kindred matters; injuries to patients and others; detention of patient against his will; hospitals and institutions for persons of unsound mind and mental defectives; loss of or damage to patients' property in a hospital or a nursing home; births and deaths in hospitals; professional confidence and cognate matters; ownership of medical records; poisons and dangerous drugs and radioactive substances; professional qualifications; law of master and servant as affecting hospital staffs; statutory regulation of conditions of employment; hospital rates, taxes and duties; raising money for hospitals; gifts by will to hospitals; hospital charges; trespassers; search and arrest of suspected persons; the nurse's contractual position; nursing homes and agencies for the supply of nurses; National Health Service Acts, 1946 to 1952; the Public Health Act.

While some of the material contained in this volume relates specifically to the situation in Great Britain, most of the work is directly applicable to hospitals in Canada. Law in Canada is based primarily on British law, although in the province of Quebec there is a French as well as a British heritage. English decisions and principles weigh heavily in our courts; and this practical exposition of basic principles and viewpoints should be helpful.

THE ROCHESTER REGIONAL HOSPITAL COUNCIL. By Leonard S. Rosenfeld, M.D., M.P.H., director of the Medical Care Evaluation Studies of the United Community Services of Metropolitan Boston; and Henry B. Makover, M.D., medical director of the Central Manhattan Medical Group. A Commonwealth Fund book, Harvard University Press. Price $3.85. Pp. 204. Published in Canada by S. J. Reginald Saunders and Company Limited, Toronto.

The Rochester Regional Hospital Council has attracted much attention as one of the most significant experiments in developing hospital service on a regional basis. This book presents a detailed account and an evaluation of the program by an impartial outside agency, the Institute of Administrative Medicine of Columbia University School of Public Health.

The Rochester project was started in 1946 in an effort to determine in what ways, and to what extent, concerted voluntary action by hospitals through a representative regional organization might stimulate and encourage an improvement in the quality of services rendered and make possible more efficient and co-ordinated use of the region's medical facilities. The program included the joint planning of hospital building and expansion; the joint operation of institutional services which can be performed more efficiently by a group than by individual institutions; and the pooling of clinical, administrative, and technical skills.

This report includes a description of the eleven-county area, a detailed account of the organization and activities of the Council; a discussion of its educational activities for physicians, administrators, nurses, other hospital personnel, and trustees; and an account of the Council's many services, such as research, advice, and assistance in various problems of hospital administration and operation, co-operative purchasing, uniform accounting, and analysis of professional activities. The authors evaluate the program in its various aspects and offer suggestions for the improvement of the Council's services.

THE NURSE AND THE MENTAL PATIENT—A study in Interpersonal Relations. By Morris S. Schwartz, Ph.D., and Emmy Lanning Shockley, R.N. Price $3.50. Pp. 289. Published by the Russell Sage Foundation, New York.

As indicated by the title, this study is concerned exclusively with interpersonal relationships — one extremely important aspect of patient care. The book is written for those mental hospital personnel who are in direct and continuous contact with patients. These personnel form emotionally important relationships with patients, make up their social environment, and leave their mark on them for good or ill. Through these relationships personnel can make a significant contribution to improvement in the patient.

The book is organized into two parts. Part 1 deals with selected types of problem situations that recur in caring for mental patients. Part 2 discusses how the nurse might communicate with the patient and develop a better understanding of him.

This volume will be particularly helpful to those leading discussion groups with nurses and attendants who are undertaking psychiatric nursing for the first time, as well as to those who have had considerable experience with patients. Many of the concepts and attitudes set down are almost equally useful to all nursing situations.

HUNTERDON MEDICAL CENTER — The story of one approach to Rural Medical Care. By Ray E. Trussell, M.D. A Commonwealth Fund book, Harvard University Press. Price $4.15. Pp. 236. Published in Canada by S. J. Reginald Saunders and Company Limited, Toronto.

This is the story of a community's effort to establish a hospital. After deciding that it needed a hospital, the community paused to study its medical and health needs, and finally developed a medical centre with a county-wide program embracing many noteworthy features. The idea originated in 1946 and the resultant Hunterdon Medical Center opened its doors for service in July, 1953. It is a small rural hospital directly and intimately associated with a large urban university medical centre. The medical centre represents a new formula for medical service in a rural community, in which patients remain under the care of their family physicians, who in turn have the complete co-operation, as well as guidance when needed, of a full-time specialist staff. In this type of organization the full-time staff supplements the family physician but does not supplant or compete with him. The environment is that of a university-type medical centre in which education and training as well as investigation play such important roles in medical care.

All those concerned with the availability and quality of medical care in the rural area will find the story of

(Concluded on page 82)

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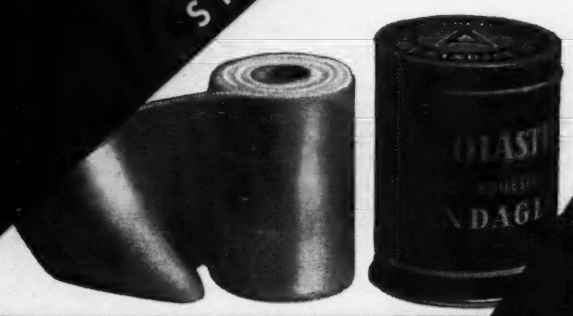

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Book Reviews

(Concluded from page 80)

the Hunterdon Medical Center in New Jersey of genuine interest.

THE PRACTICE OF PSYCHIATRY IN GENERAL HOSPITALS. By A. E. Bennett, M.D., Associate Clinical Professor of Psychiatry, University of California School of Medicine; Eugene A. Hargrove, M.D., Assistant Professor of Psychiatry, University of North Carolina School of Medicine; Bernice Engle, M.A., Research Associate, Department of Psychiatry, University of California, School of Medicine. Price $4.00. Pp. 178. Published by University of California Press, Berkeley, Cal.

Recognition of the medical, economic, and social advantages of psychiatric units within general hospitals has been spreading. The organization and operation of such units presents many special problems, however, some of them unfamiliar to hospital administrators, psychiatrists, and other medical men. This volume answers many of the questions which must be considered in setting up such units and will be of fundamental importance to anyone concerned with progressive hospital practice.

The book deals with staffing and training problems, intra-staff relationships, and requirements for nursing, occupational therapy, psychological, and social service staffs. It examines practical problems of administration and financing. Methods are suggested for construction or remodelling of psychiatric facilities. Referral procedures are described, with considerable material on the proper way of dealing with relatives of patients. One chapter discusses the medico-legal phases of admission, commitment, and discharge. Legal forms recommended as standard proccdure are included, together with other means of protection against malpractice suits. The limited coverage of mental illness costs now provided by insurance plans is examined; and a program is outlined for developing broader coverage under realistic prepayment rates. Day hospitals, which have been found particularly adaptable to the care of certain kinds of mental illness, are described in a chapter written by the head of one such institution. Useful information is also provided on special treatments given in psychiatric units. A concluding chapter suggests how the basic problems of expanding and improving general hospital psychiatric facilities can be solved. Brief reference lists follow each chapter.

HEALTH INSURANCE — WHAT ARE THE ISSUES? Price $1.00 Pp. 60. Published by the Canadian Welfare Council, Ottawa

This booklet, a timely discussion of a current issue, is planned to help clarify public thinking. Questions having to do with the provision and financing of health services have concerned the Canadian Welfare Council for some time; and a special committee to study them was appointed by the board of governors in September, 1951. During the years since this committee, representing wide experience and varied interests, has met frequently and endeavoured to keep itself and the Council informed about proposals and developments in Canada and other countries. The present pamphlet is the outcome of the committee's work.

THE HAMILTON GENERAL HOSPITAL SCHOOL OF NURSING 1890-1955. By Marjorie Freeman Campbell. Price $4.50. Pp. 172. Published by the Ryerson Press, Toronto, Ont., 1956.

This exciting account of earlier struggles and evolution to the present 1,241-bed Hamilton General Hospital is an instructive piece of Canadian social history. Marjorie Freeman Campbell begins her story by recalling conditions when the great cholera epidemic of 1832 gave rise to Hamilton's first civic venture in hospitalization... "rude huts were erected on the bay shore to house sick and dying passengers from a ship in the harbour."

Progressive stages in the development of the hospital and its nursing school are described in a warm, lively style. The author's skill in relating pertinent incidents brings even her minor characters to life. Here is the story of nurse training over 65 years and chapters about persons prominent in the hospital's progress. It is related that after the founding of the Hamilton General Hospital in 1890, a choice was exercised in acquiring nursing personnel, and the status of nurses improved. The profession has come a long way from the designation "servants" and a "long way from the 7-day week of 24-hour duty for which $10 was felt to be exhorbitant, to the present $10 for an eight-hour day."

With their history and their humour, these pages live as an inspipring memorial to those doctors and nurses whose efforts developed a great project for humanity. The casual peruser, and all who have been associated with Hamilton General Hospital, will find them rewarding reading.—*K.A.L.*

Twenty-Eighth

Biennial Meeting of the

Canadian Nurses' Association

THE twenty-eighth biennial meeting of the Canadian Nurses' Association, held on the campus of the University of Manitoba, Winipeg, Man., began on Monday, June 25. Following the invocation and official opening by the Hon. D. L. Campbell, Premier of Manitoba, the presidential address was delivered by Gladys J. Sharpe, of the C.N.A. Miss Sharpe stressed the importance of committee work which facilitates sound planning and co-ordinated action. "Our organization is too large", she said, "and our meetings too brief to do more than plan for the work to be done, outline general policies for doing it and make final decisions." Miss Sharpe drew attention to forthcoming reports by the five standing committees: Constitution and By-Laws, Finance, Nursing Education, Nursing Service and Publicity, and Public Relations.

The keynote address was delivered by the Honourable T. J. Bentley, Minister of Public Health for Saskatchewan, who prefaced his remarks on Saskatchewan's expanding Health Services Program by pointing out that "public opinion is no longer complacent over poverty, ill-health, and inequality of opportunity around us." The Minister enumerated the four broad categories into which services could be divided. The first of these were Community Preventive Services — in which health regions are organized where effective campaigns against polio and rheumatic fever have been carried out, and where, with regard to tuberculosis, the province has "moved so far in control that we even talk of virtual eradication". Second, Mental Health Services — where new tranquilizing drugs have been used to good effect, and four out of every five patients recently admitted can within a few weeks or months be returned to their homes in an improved condition. Important investigations are also under way into the nature of schizophrenia. Medical Care and Hospital Services — here figures were given for prepayment plans on a voluntary basis, while at the same time the minister stressed that "we have no class medicine for the poor". About one person in five in Saskatchewan is admitted to hospital every year, he said. Admissions are free and unrestricted for all medically required hospitalization. The hospital bed total is about 50 per cent higher than the national average. Finally, education and research were mentioned.

Following Tuesday's busy finance session, delegates on Wednesday watched a group of nurses stage a dramatic interpretation of the Head Nurse Study, and voted approval of a statement of national nursing service policies that included the Internation Code of Nursing Ethics. Nursing Service Committee Chairman, Alice Girard, director of nursing, Hôpital St.-Luc, Montreal, said that a staffing guide is urgently needed, and announced publication of an "Orientation Manual" designed to introduce new nurses to their staffs. Margaret Arnstein, R.N., M.P.H., chief of Division of Nursing Resources, U.S. Public Health Services, in introducing her topic "Improving Nursing Service with or without Studies", said, "there is something in life besides studies, things *can* be accomplished without necessarily doing a study first". Miss Arnstein cited team nursing as an example of important changes that may result not from formal studies, but "because some one person, or group, thought it would be better to do something a new way . . . from a series of observations." In order to solve a problem, she said, one must first realize that it exists. In discussing better utilization of nursing time and personnel, the speaker noted that when it was possible to relieve head nurses of non-nursing duties, job-satisfaction increased noticeably among the entire staff. Citing the danger of nursing the equipment attached to the patient instead of the patient, Miss Arnstein quoted Dr. Hargreaves, director of Mental Health in the World Health Organization, as saying that he would rather have mothers take care of their children in hospital and risk a few infections from faulty techniques, than risk what he thought were much greater chances of impairing the child's emotional health if he were separated from his mother. In conclusion, she said, research in nursing is only beginning.

On Thursday, sessions on Nursing Education and "Better Nursing through Accreditation" were chaired respectively by Evelyn Mallory and Dr. Rae Chittick. Delegates voted approval of a two-year study of accreditation of schools of nursing in Canada, proposed by the C.N.A.'s Nursing Education Committee. American experience in this field will facilitate the study of at least 20 of Canada's 174 hospital schools of nursing. Chairman of the special sub-committee on accreditation is Sister Denise Lefebvre, director of nursing education at the Institut Marguerite d'Youville, Monreal, P.Q.

In the afternoon, discussion groups heard an address by Mildred Schwier, R.N., M.A., director of the diploma and associate degree programs for the National League of Nursing, New York, entitled "Creative Nursing — the Goal of Nursing Education." Miss Schwier warned of barriers today to educational nursing progress. She stressed the need for changes through which the student nurse will be accepted as a learner rather than a worker; and she pointed out that the quality of education for nurses today controls the kind of care patients receive tomorrow. She asked whether future students will "be bored automations or creative nurses". Information gathered through the N.L.N. improvement program revealed that many schools had no stated objectives in 1956 — too many of them relying on late nineteenth century concepts. In progressive nursing education programs, Miss Schwier said, there is less lecturing, more conferences, greater effort to relate theory and practice, and more emphasis for the student nurse on creative problem solving. "How can the student nurse assigned six or seven patients to be washed, fed, dressed, medicated, ambulated and recreated find time to be a student?" The speaker made the challenging suggestion that immediate practical considerations of using the labour services of student nurses were occupying time that should be devoted to education.

Friday's closing session began with an address "Signposts at Geneva", by Dorothy M. Percy, chief nursing consultant, department of National Health and Welfare, Ottawa. Miss Percy reported on the technical discussions on nursing which recently took place at the Ninth General Assembly of the World Health Organization in Geneva, Switzerland. The speaker gave her impressions of the organizational efficiency at Geneva and of the stimulating exchange of views of delegates from many lands. This diversity of representation did, however, "make an approach

(Concluded on page 116)

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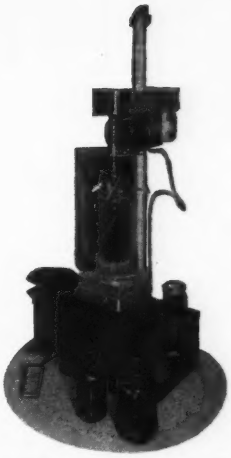

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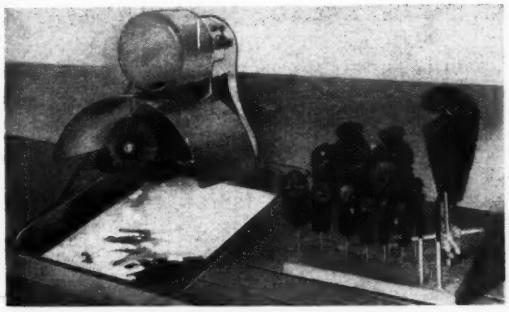

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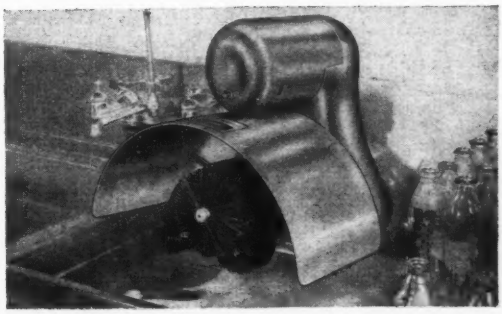

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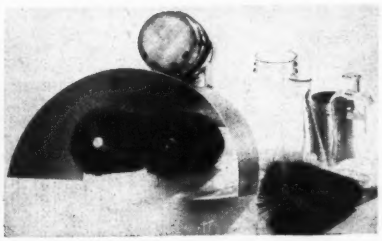

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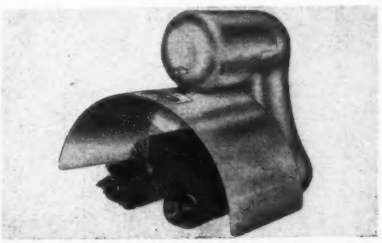

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Provincial Notes

Newfoundland

ST. JOHN'S. Plans are now complete for the new $1,000,000 wing to be added to the St. John's General Hospital. Construction may be slowed as a result of the American steel strike. Most of the new wing will be occupied by a cancer clinic, which will be used for the early diagnosis and treatment of cancer as well as for research into the causes and cure of the disease. The new wing will also house the public health laboratory.

New Brunswick

SAINT JOHN. Construction of the new St. Joseph's Hospital, to be built at an estimated cost of $3,200,000 is proceeding rapidly. The foundation and structural steel for the out-patient wing have been completed and brickwork will get under way soon. Three storeys of structural concrete have been completed for the service wing. Structural steel is also being erected for the main wing and the foundations are being poured for the chapel building. The new hospital, scheduled to be completed in mid-1957, will have accommodation for 187 adults, 22 children and 50 bassinets.

Quebec

MONTREAL. The Queen Elizabeth Hospital has received a grant of $6,300 for cancer research from the Quebec Division of the Canadian Cancer Society.

Ontario

BRAMPTON. A 762-bed hospital for aged persons is to be constructed near Brampton at an estimated cost of $6,000,000. The hospital will consist of eight separate units, of 90 beds each, together with a large administration building.

ENGLEHART. A grant of $5,041 from the Atkinson Foundation will be used to provide operating room and delivery room equipment to the Englehart and District Hospital.

LONDON. New x-ray equipment costing $32,000 is part of a major program to improve x-ray and out-patient services at the Victoria Hospital. Architects are now preparing plans for a two-storey extension to the east side of the main hospital building to house these services.

OSHAWA. Equipment for the laboratory in the new $2,500,000 wing nearing completion at the Oshawa General Hospital will be purchased with a $24,795 grant from the Atkinson Foundation. With the addition of the new 130-bed wing the capacity of the hospital will be increased to 357 beds. Provision is made in the new wing for a modern 65-bassinet nursery, greatly expanded x-ray department and laboratory, as well as new pharmacy, central supply, enlarged kitchen and service facilities.

TORONTO. The new 160-bed Queensway Hospital has been officially opened. By following a horizontal ranch-style construction, the hospital was built at a cost of $2,225,000. It highlights a central core of operating, treatment and x-ray rooms surrounded by wings containing the patients' rooms. Much has been provided to contribute to patients' comfort. The rooms are equipped with portable TV sets and a central control system offers a choice between two radio stations or tape-recorded music. The rooms are also equipped with two-way intercommunication systems so sensitive that a nurse or doctor can tune in on a patient's breathing without going into the room to disturb him. The nurses' residence provides a suite for every four nurses — complete with an ultra-modern kitchen.

Manitoba

GIMLI. A new $33,000 hospital at the United Church Fresh Air Camp has been opened recently. The 20-bed hospital is especially constructed and equipped to care for children and adults who can not join in regular summer camp activities. The frame one-storey structure, which includes eight wards, a lounge, kitchen, and nurses' quarters is expected to accommodate more than 150 persons from across Manitoba each summer.

WINNIPEG. A new north wing is now under construction at the Winnipeg General Hospital, at an estimated cost of $4,500,000. The seven-storey addition will provide facilities for 36 private and 324 public beds. The building is of reinforced concrete.

WINNIPEG. A $3,000,000 structure, the new Winnipeg Children's Hospital is nearing completion. Construction will commence shortly on a new $475,000 three-storey nurses' residence and school of nursing.

Saskatchewan

MILDEN. Plans for a $95,000 hospital to be built in Milden are being prepared. The structure will be of masonry construction, one storey and steam-heated.

SASKATOON. St. Paul's Hospital, in west Saskatoon, will be extended to 320 beds from its present 279-bed level by the addition of a new wing.

SHELLBROOK. A 22-bed extension to the Shellbrook Union Hospital was recently opened. The brick building is equipped with hot water and air-conditioning systems, and a pipeline oxygen system to supply all areas of the hospital. The main floor includes wards, waiting room, administration offices and storage space. The basement includes a staff dining room, board room, kitchen and serving rooms, and two health clinic offices. The halls are decorated in pastel shrimp with Indian pottery trim and the wards are in green, buckskin and shrimp.

SWIFT CURRENT. Representatives of hospitals in Southwest Saskatchewan recently held the first meeting of the Southwest Regional Hospital Council. The speaker, T. J. Bentley, Minister of Health for Saskatchewan, pointed out that this was the first hospital council of its kind in Canada. The council approved the appointment of a medical social worker, whose services, as with the other consultant staff, would be shared among all the hospitals. An executive board was elected comprising G. B. Cowan (Swift Current Union Hospital), E. C. Glass (Maple Creek Union Hospital), H. Gill (Leader Union Hospital), Mrs. E. M. Rudolph (Gull Lake Union Hospital), C. J.

(*Continued on page 138*)

With the Auxiliaries

Extra Services Planned At the Queensway

A gift shop, stocked with patients' necessities as well as special gift items, will be operated in Queensway General Hospital, Toronto, Ont., by the more than 400 volunteer workers of the Women's Hospital Auxiliary. The shop, decorated in pastel tones of powder blue and primrose yellow has custom-built show cases to display the knitted, crocheted and hand-sewn articles as well as the special gift items of china, costume jewelry, cosmetics, shaving kits, baby supplies and convalescents' requirements. In addition to the shop, a "sunshine" cart will be circulated through the hospital by the women, to the patients confined to bed. Those extras which add comfort to a patient such as candy, magazines, pocket books, cosmetics, stationery supplies and similar items, will be carried on the cart. Mrs. W. K. Fenton is the first convener of the auxiliary cart donated to the hospital by the Kingsway Women's Welfare Club in memory of her late husband, the Medical Officer of Health for Etobicoke Township.

• • • •

Equipment for Hospital

The Senior Auxiliary to Mission Memorial Hospital, Mission City, B.C., recently purchased a refrigerator for the diet kitchen and two regulation hospital screens. New draw curtains for wards will also be obtained by this auxiliary. They will donate three new screens to the Old Age Pensioners' home.

• • • •

New Auxiliary Formed

Organization of a new auxiliary to work in the interests of the Dartmouth Children's Hospital, N.S., is being carried out.

• • • •

Membership Drive

Kimberley District Hospital Women's Auxiliary, Kimberley, B.C., recently held a membership drive through the area, rallying the membership total to 840 women. This they believe to be one of the highest of any non-metropolitan hospital area in Canada.

• • • •

Support for New Addition

The Women's Auxiliary, Oshawa General Hospital, Oshawa, Ont., have promised to give $10,000 towards the new hospital addition, of which $7,500 has already been donated. In addition, the auxiliary intends to equip and maintain a gift shop.

• • • •

Deluxe Bassinets

A number of deluxe bassinets for the nursery of the Lachine General Hospital, Lachine, P.Q., have been purchased by the Birthday Club of the Women's Auxiliary. The bassinets, each costing $210, are self-contained units with cupboard and drawer space for supplies to be used for the individual baby, and surrounded on three sides by plexi-glass.

• • • •

Annual Scholarship Initiated

Tt the latest Saskatchewan Hospital Auxiliary Convention, it was decided to give annually a scholarship of $100 to a Grade Twelve girl who is going to make nursing her career.

Annual Meeting Shows Many Achievements

Ten regular meetings were held last year by the Ladies Aid of the Prince County Hospital at Summerside, P.E.I. The Aid made arrangements for the nurses' graduation ceremony and their dance, supplying corsages and two prizes. At the capping ceremony in March, two prizes were awarded to members of the junior class for general proficiency. At Christmas, gifts of money were presented to each student nurse. Many hundreds of dollars worth of equipment for the hospital was purchased during the year, including one electric scrubber, two vacuum cleaners, one electric floor polisher, one frigidaire, two instrument cabinets for the operating room at a cost of $240 and instruments for the operating room costing $395.42. The sum of $1,730 was raised in the year's activities.

• • • •

Weekly Bargain Centre

The Women's Auxiliary to Matsqui-Sumas-Abbotsford General Hospital, Abbotsford, B.C., holds a "bargain centre" sale every Tuesday morning from 10 to 12 o'clock. They deal in such articles as used clothing, old dishes and jewelry, et cetera. It brings them $40 a week in profits.

• • • •

Improvements in O.T. Department

A successful annual garden party has provided the members of the Gorge Road Hospital Auxiliary, Victoria, B.C., with $1,200, which will be directed towards improving facilities in the occupational therapy department.

• • • •

Girls' Aid Active

A suction machine for the operating room at the Salmon Arm General Hospital, Salmon Arm, B.C., is to be purchased by the Girls' Hospital Aid, at a cost of $140. Volunteers from the group served at the concession booth at the Shuswap Lake Regatta.

The inscription on the cake, "Best Wishes, Queensway Hospital," held by Mrs. J. Cox, chairman of the Women's Auxiliary Alderwood branch, expresses the sentiments of more than 400 women in the south-western section of Metropolitan Toronto – members of the Women's Auxiliary to Queensway General Hospital, Toronto, Ont. Mrs. George Finnett, left and Mrs. S. Ziegler were among the many active members attending a miscellaneous shower of gifts for the Auxiliary's gift shop.

Food and Nutrition in Angola

Alice K. Strangway, M.A.*

ANGOLA is an overseas province of Portugal situated in West Central Africa. In Angola there are 4,000,000 Africans of Bantu stock and about 100,000 Europeans mostly Portuguese but with a sprinkling of Germans, Italians, English, Americans and Canadians and 30,000 people with black and white blood mixed. About two thirds of the 4,000,000 Africans go to bed hungry from too few calories, or suffer from a poorly balanced diet. Angola is essentially an agricultural country with an area of 481,351 square miles and over 1,000 miles of coast line. It lies between 5 and 18 degrees from the equator; yet the climate is subtropical, and favours agricultural pursuits. Two crops a year can be grown with irrigation, but there is much erosion, for the fields of the Africans are outworn as they have not practised rotation of crops or fertilization. Sugar cane flourishes, and a good grade of coffee is exported—much of it going to Canada, where it is traded for Newfoundland codfish, of which the Portuguese are fond. Corn, wheat and beans grow well on the uplands, and rice in the swampy river valleys—though it is necessary to import wheat flour. Flour milled in Angola must, by law, have most of the bran coats removed; and, since there is no enrichment with B vitamins, the bread is low in vitamin and mineral content. Yellow palm is rich in vitamin A, and is used for food and soap manufacture; presses extract the oil from oil seeds for food uses also. Salt is extracted from sea water and —with the iodine from ocean fish—the recent use of this has reduced the figure of 75 per cent, which represents the number of school children suffering from enlarged thyroid glands 25 years ago. Fish is canned, dried and salted, or made into fertilizer meal. Cattle owned by Africans are of poor quality and give little milk, although in the South there are improved breeds. Pigs are also of an inferior type, although improved breeds are being introduced. Generally, the African people suffer from malnutrition that is accentuated during the hunger months of October to December.

The above is an abbreviated version (published through the courtesy of the author) of an article that originally appeared in the Journal of the Canadian Dietetics Association, July 1956.

In the North and East, manioc (cassava) forms the basis of the African diet. In the central and southern parts 80-90 per cent of the calories come from cornmeal. Manioc is almost pure carbohydrate; manioc contains some protein and fat, as well as minerals, B vitamins and fat soluble vitamins. But the African women in the preparation of the cornmeal pound the corn on the rocks or in a mortar and pestle made from a tree trunk, and then winnow it, removing most of the bran layers and the germ—thus losing most of the protein, the fat, mineral and vitamins. Education campaigns are promoting the use of hand mills to counteract this.

All Africans use beans, but milk and eggs are used only by a few educated Africans. The chickens are mostly like wild birds and lay only a few eggs, which are usually exchanged for salt at a store. What little milk is obtained from cattle is also usually sold. Meat is only eaten on festive occasions. The dried fish from the coast is a valuable addition for those able to buy it. A few unusual protein foods, such as rats, white ants, and caterpillars add a good, but insignificant amount of protein to the diet.When locusts invade the country, they also serve as a food—although, since they bring famine with their destruction—it is fortunate that they do not come often. Most protein is derived from vegetable sources, but the corn and beans used are often too low in food values to support normal growth. The lack of whole grain cereals and milk means that riboflavin, nicotinic acid, thiamine and other vitamins of the B complex are in short supply.

Obvious Deficiencies

The evidence of these deficiencies can be seen particularly in young children. At weaning of infants, no suitable substitute for mother's milk is available. Many children have grossly enlarged livers. Oedema of the face, feet, and sometimes of the whole body occurs. Significant changes in the colour of skin and hair occur; the hair loses it curl and becomes reddish-brown and sparse—in contrast to the usual healthy hair of the Africans. The skin also reveals symptoms of multiple food deficiencies, but these will disappear promptly with a good varied diet. A new growth of hair will replace the unhealthy red hair.

In spite of the palm oil and the lard which are distributed throughout Angola, the majority of Africans lack sufficient fat in their food intake. It may be relevant here to note that there has not been a case of coronary heart disease diagnosed during 29 years. But while some children have knock knees, bow legs or deformed chests, the incidence of these is not as great as one would expect with the shortage of vitamin D. The large amount of sunshine probably prevents the severe manifestation of rickets.

Primitive villages do not have fruit trees or vegetable gardens. Green leaves such as squash or beans are cooked for a long time in open pots with water, thus destroying most of the vitamin C content. Wild fruits and nuts add some variety. During the hunger months, small sweet potatoes—with little vitamin C content— are almost the only food for many. Conditions such as spongy gums are attributed to this deficiency—particularly onyalai, a disease found only in Africa. This haemorrhagic disease may be successfully treated by massive doses of vitamin C.

Foods used are low in calcium content, and this is enhanced by the soil deficiency in calcium. Contrary to the belief that primitive people have good teeth, the teeth of the Angola Africans show a high incidence of dental caries. Sugar is not used, and the fluorine content of water and food is unknown.

Urbanized Africans, on the other hand, are adding more carbohydrate in the form of sugar, white bread and polished rice to their already high carbohydrate intake. Although they are also beginning to use meat, dried fish, fruits and vegetables, they still do not use milk or eggs. This increase in total calories, mostly carbohydrate, is resulting in obesity. No doubt malnutrition plays a role in the many eye conditions such as corneal vascularization, blepharitis, conjunctivitis and cataract. It complicates almost every disease found in the Angolan Africans. Tuberculosis is spreading

(Concluded on page 132)

* *Mrs. Strangway has lived for 26 years in Angola where her husband, Dr. Walter Strangway, is a medical missionary with the United Church of Canada, in the Mission hospital at Chissamba. For the past year, while on furlough, she has been a research associate in the Department of Food Chemistry, University of Toronto.*

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At Port Colborne General Hospital, Port Colborne, Ont., the food service unit is placed on a wagon, ready to be taken to the patient.

Vacuum Sealed Food Service

There are three basic units in the thermos vacuum packed container system for serving food: a container, an infra-red dish heater, and a special tray. The insulated stainless steel container holds a removable glass dish which has three partitions for hot foods. The dish is pre-heated and sterilized in an infra-red heater (in which four plates can be inserted on a metal tray) for approximately one minute at 100 degrees F. The dishes are then placed in the bottom section of the container, ready for packing. When packed, a self-forming vacuum seals in the original cooking heat and savoury goodness. There is no intermingling of flavours or aromas. A serving of additional hot vegetable or desert may be placed on top of the dish lid, along with hot breads or toast.

On completion of packing, the top section of the container is clamped over the bottom one, entirely sealing in the hot meal. The unit is then placed on the patient's tray (in place of a dinner plate) along with dessert, et cetera. A special tray cart which contains 20 trays also carries three insulated steel containers for hot and cold beverages. Meals will remain as hot as they came off the stove for a minimum of two hours; chilled foods can also be served in this fashion.

Medical Statistical Service Set Up

A Commission on Professional and Hospital Activities has been established by the American College of Surgeons, American Hospital Association, American College of Physicians and the Southwestern Michigan Hospital Council. Its purpose is to conduct a medical statistical service that will help hospitals to simplify medical records and analyze them more effectively for the improvement of medical and administrative practices. The Commission has received a grant of $260,000 from the W. K. Kellogg Foundation, Battle Creek, Michigan, to support the program for three years, after which it is expected the service may be continued on a self-sustaining basis. The Commission will establish its headquarters and conduct its services at Ann Arbor, Michigan.

It is an outgrowth of the Professional Activity Study carried on for the past three years by the Southwestern Michigan Hospital Council and directed by Dr. Vergil N. Slee, director of the Barry County Health Centre at Hastings, Mich., and secretary and director of the new organization.

"The work in Southwestern Michigan has demonstrated possibilities that the methods used there could be of significant help to hospitals," said Dr. E. L. Crosby, treasurer. "The establishment of this Commission, with sponsorship of three national organizations, makes possible the broadening of the work and will thus extend the benefit to many other hospitals and also permit a more thorough evaluation of its applicability on a national scale."

With 23 member hospitals of the Council participating, the Professional Activity Study of the Southwestern Michigan Hospital Council developed a simplified method of collecting and reporting medical statistics for hospitals. Under this system, a single sheet reporting the medical diagnosis and treatment was completed for every patient discharged from each member hospital. These records were forwarded to a central service bureau, where they were tabulated by machine and returned to the hospital as summarized records permitting study and comparison of the performance of individual doctors on the staff, and comparison of results among hospitals. Last year, the Professional Activity Study handled 144,000 discharges, Dr. Slee said.

"Organization of the Commission will permit us to extend the service to other hospitals, and to experiment with services in other areas of medical and hospital interest. The program should expand very slowly, so that we may work intensively in helping participating hospitals to utilize the information available to them and strive constantly for the kind of studies and data that will be of maximum usefulness."

The Michigan experience indicated that the service could be furnished at a cost within the reach of small community hospitals, and that in many cases mechanization of medical statistical procedures may actually save hospitals money.

Physical and Occupational Therapy

Dr. A. T. Jousse, director, Division of Physical and Occupational Therapy, University of Toronto, has advised that graduates of the courses in Occupational Therapy, Physical Therapy, and Physical and Occupational Therapy may identify their professional qualifications by the use of the letters Dip., O.T., Dip., P.T. or Dip., P and O.T. after their names depending on the course in which they have graduated. — *Canadian Journal of Occupational Therapy.*

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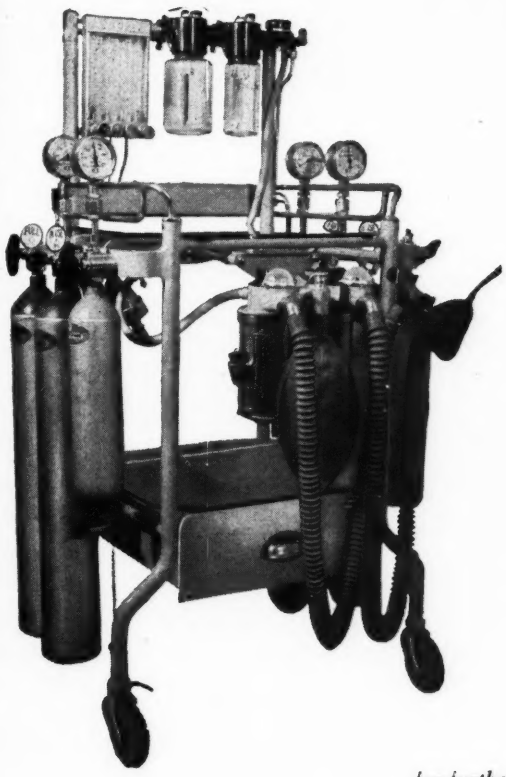

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Here and There

Tiny Cars for Disabled

A trial shipment of 23 miniature automobiles have been distributed to severely disabled veterans by the Yugoslav Social Welfare Ministry, and have proved highly successful for cheap personal transport adapted to hands-only control. In accord with Yugoslav policy, they were admitted duty-free into the country for the use of the handicapped. The machines, of the "Isetta" type, are manufactured in West Germany from Italian design. They are fitted with an air-cooled two-stroke motor, provide weather-proof transport for two adults and a child, and can be hand-operated with very inexpensive modifications. The machines are capable of a speed of 45 m.p.h. at 80 to 100 miles to the gallon, and can be parked and manoeuvred as easily as a motor-scooter, of which handy form of transport they are a development.—*World Veteran*

Seoul National Medical Centre

Plans for the rebuilding of Seoul City Hospital into a modern medical centre run on Scandinavian lines are rapidly becoming a reality with the arrival in Seoul of the Swedish Surgeon General, Admiral C. E. Groth, and a team of Swedish architects and construction engineers.

Surgeon General Groth is Chairman of the Scandinavian Board for the National Medical Centre in Korea. He is accompanied by Gustaf Birch-Lindgren of Stockholm, who is in charge of the architectural and engineering phase of the work.

The National Medical Centre is being established jointly by the three Scandinavian countries of Denmark, Norway and Sweden, the government of Korea and the United Nations Korean Reconstruction Agency (U.N. K.R.A.). While the main purpose is to give treatment to people who need treatment, it is possible that the most lasting result of the Scandinavian effort will be to train Korean medical officers and nurses in the Scandinavian way of administering a hospital.

"The Centre will be a fully equipped general hospital," said Surgeon General Groth. "We shall bring highly specialized people for every department. We shall try to get one third of the staff from each of the Scandinavian countries. They will stay for a period of five years. We hope the Centre will be in operation at the beginning of 1958."—*U.N. Press and Publications Division*

A "European Village" for Tubercular Displaced Persons

Work was recently begun on the establishment of a "European village" for tubercular displaced persons and their families, at Aachen, Germany. The idea originated with Father Pire, a Belgian Dominican who founded the Society for Aid to Displaced Persons in Belgium a few years ago. Faced with the agonizing choice between separation from a loved one and starting a new life of their own in a new land, members of the sick person's family frequently — and understandably — give up their own chances to emigrate and stay with those whose illness makes them unacceptable as immigrants.

In the beginning, the village will contain ten one-family cottages, six of which will be occupied by families chosen from the camp for displaced persons in Augustorf, near Detmold (Westphalia), where the most destitute of the refugees are now living. Most of them are Poles, Ukrainians or Hungarians.

The persons chosen will work according to their capacities, so that the families will not be a burden to the community. The children will go to the local German school.

—*The World Veteran*

Spain Ratifies United Nations Opium Protocol

In June, Spain became the 18th nation to ratify or accede to the United Nations Protocol for limiting and regulating the cultivation of the poppy plant and production, trade, and use of opium.

To date the following states have either ratified or acceded to the Protocol: Australia, Canada, China, Cuba, Denmark, Ecuador, Egypt, France, Guatemala, India, Japan, Luxembourg, Monaco, Pakistan, Panama, Philippines, Spain and the United States. Twenty-five ratifications or accessions are required before the Protocol comes into force including at least three of the following producing-exporting states: Bulgaria, Greece, India, Iran, Turkey, U.S.S.R., Yugoslavia, and at least three of the following manufacturing states: Belgium, France, Federal Republic of Germany, Italy, Japan, Netherlands, Switzerland, United Kingdom and the United States.

The aim of the Protocol is to limit the production and use of opium, and hence to prevent the illicit traffic by indirect means, namely by limiting the stocks of opium, by restricting the number of producing-exporting countries to the seven mentioned above, and by regulating the areas under poppy cultivation.

Royal Women's Hospital, Melbourne

The new Royal Women's Hospital, Melbourne, Australia, 16 storeys in height, designed by Leighton Irwin, C.M.G., F.R.I.B.A., & Co., is designed to handle 10,000 births a year, and is estimated to cost £5,000,000. There will be 125 private and intermediate beds, and 500 public beds.

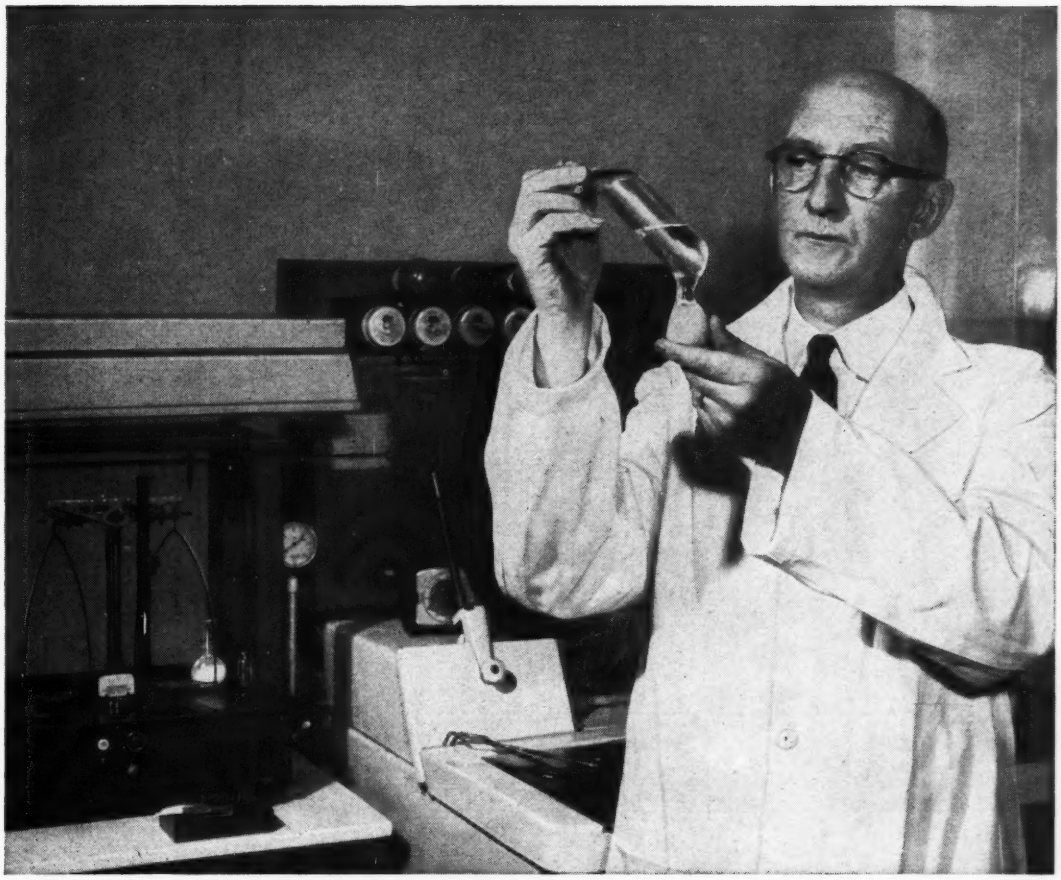
San Francisco Home Care Program

Edgar Munter, M.D., medical director of a pilot home care program operated through Mount Zion Hospital, San Francisco, notes that while "care in the home" usually means physician's services, with nursing care when available, "home care" provides selected homebound patients with a full range of services arranged for and co-ordinated through one administrative agency or institution.

The San Francisco program includes diagnostic services, medical and nursing care, physical and occupational therapy, homemaker and social services, vocational counselling, dietitian services, medical supplies and equipment and prosthetic appliances, transportation, hospitalization, home teaching (through the Board of Education) and other services as needed.

"Home care is a single aspect of a total medical care plan for the patient . . . not simply a way to save money . . . or a new method of training professional personnel . . . a program which through co-ordinated effort is designed to meet the individual needs and related social, economic and vocational needs of those patients who may be adequately treated at home."

—*Newsletter*



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(Concluded on page 51)

tion is seldom achieved, and most can live a full life if given the opportunity. Few jobs require full physical fitness, and a disability may even be an advantage, as in the case of midget riveters, and of people in which the loss of one sense has sharpened another. However handicapped people often have the probems of social relationships, limited choice of vocation, personal adjustments to handicap, and educational problems. The dietitian is included as one of the health authorities concerned with medical rehabilitation and the N.E.S. provides information about available jobs, counselling to discover work capabilities, registration of capacities, and referral and placement in actual jobs. It is hoped that the hiring of such people will not be based on sympathy but on recognition of a desirable worker, since, there can be no rehabilitation without employment.

Mr. N. F. Hadden of Shell Oil Co. spoke on "Personnel Policies". He stressed the fact that every supervisor is a personnel administrator. Satisfactory personnel policies are essential, even though many are unwritten. He suggested that we are often "completely off the track with personnel policies". Incentive schemes and bonus rates don't really stop dissatisfaction. Perhaps we concentrate on solving the problem of dissatisfaction rather than that of satisfaction. Too little thought is given to developing the employee. A raise prevents dissatisfaction, but doesn't increase satisfaction after the first few days. More care should be given to fitting the organizational pattern to the individual and in selecting a man for a job, gauging his ability and giving him an opportunity to improve his leadership, since leaders are developed, not born. "Personnel policies have been used as a crutch for inadequate leadership". With perfect leadership, personnel policies are not needed, and bad policies are sometimes worse than nothing at all.

Mrs. LaRue Hefner, Montana State University gave the results of her study on cake mixes. She tested white, yellow, chocolate and angel food mixes and the quality and palatability were judged higher for the pre-mixed cakes, with the exception of angel food. The time saved was 15-20 minutes per 100 servings, although cost was 6-36 cents higher per 100 servings. The pre-mix gave greater control, good cost calculation was easier, and gave less chance for error.

A highlight of the evening sessions was the Violet Ryley—Kathleen Jeffs Memorial Lecture held annually to honour the memory of two outstanding Canadian dietitians who laid many of the foundations of our profession in this country. The speaker was Dr. E. P. Scarlett, Chancellor of the University of Alberta. He showed his appreciation of both good food and good literature in his reminiscing on food through the ages and his philosophy of food.

A very successful convention closed with the 21st annual banquet, complete with birthday cake. The speaker was Dr. W. H. Johns, Dean of Arts and Science, U. of A. It was encouraging to have a man in his position so aware of the role women might play in alleviating the shortage of university graduates, his topic being "University Education for Women". If the woman graduate marries, her preparation is still good in case the bread-winner dies; it prepares her for an active life in the community, provides greater scope for effective use of leisure time, and prevents boredom. University education should result in public spirited women with a wish to raise well educated children. ●

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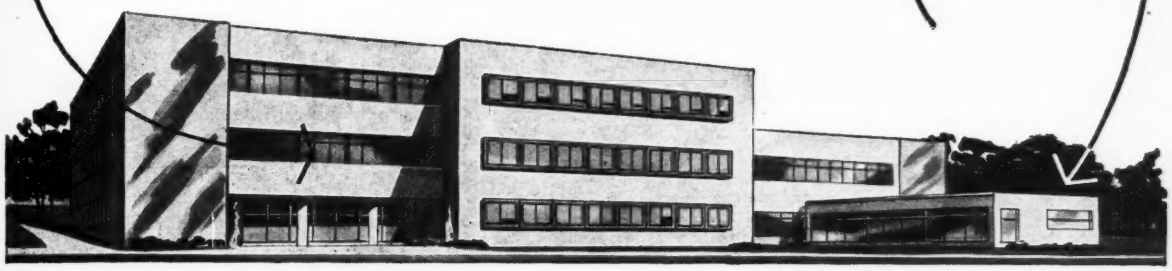

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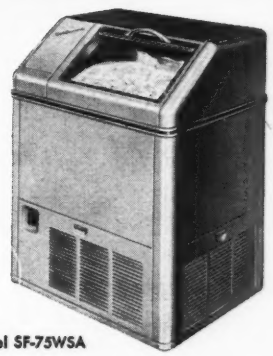

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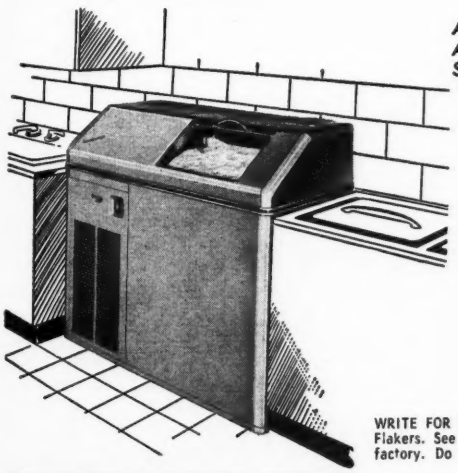

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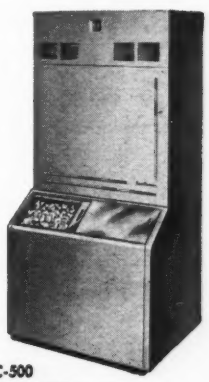

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Potatoes in the Diet

Food fallacies are not new! Probably one of the more common ones passed from person to person through the years is the idea concerning "reducing" and potatoes — "Potatoes are fattening", et cetera. Many people have become "calorie conscious" and have avoided eating valuable foods like breads and potatoes — sometimes continuing to eat chocolates or pie. All foods provide calories but no food, in itself, is fattening. A gain in weight results when the diet supplies more calories than the body is using up in activity. Even a small volume, such as a chocolate, may pack a lot of calories, while a larger volume, like a stalk of celery, contains very few calories. But if the total day's calories continually exceed the day's activity requirements, it does not matter where those excess calories are obtained.

The place of potatoes in our Canadian diet is that they should be eaten every day, by practically everyone. This does not mean that they are indispensable or that they are the most important item in our diet, because no one food can be given the coveted title of being the most important one. Eating a variety of foods as recommended by *Canada's Food Rules* is the only assurance of adequate nutrition.

This food value of potatoes is not just confined to their ability to serve as fuel, although that is their important contribution. They contain useful amounts of minerals and vitamins. Compare the *Canadian Dietary Standard* which recommends for a 120 lb. moderately active woman, 30 mg. vitamin C, .8 mg. thiamine, 1.1 mg. riboflavin, and 7.5 mg. niacin, to the nutritive value of 120 grams, (1 medium) raw potato supplying 21 mg. of vitamin C, .14 mg. of thiamine, .05 mg. of riboflavin, and 1.5 mg. of niacin. Even at much more than the present price, potatoes would be a good food to serve on every table every day.

Statistics show that, in 1954, potatoes in the raw form supplied 22 per cent of vitamin C, 11 per cent of thiamine, and 11 per cent of the niacin consumed in Canada that year. However, this is in the raw form, and people are very careless about how they handle vegetables, especially in cooking. When cooking losses are added to previous losses from storage, et cetera, the cooked potatoes may provide little except calories. Therefore, *Canada's Food Rules* recommend the frequent use of citrus fruits, raw vegetables and other fruits.—*Nutrition Notes*, May, 1956.

Food and Drug Law

Nearly a century ago, Canada passed a law relating to pure food and drugs. To that law and its expansion and development goes the credit for the safety with which Canadians can buy foods and medicines from their grocers and druggists. To ensure that standards of purity are kept at a high level, our food and drug inspectors keep unfailing watch over production and sales of all foods and drugs, whether domestic or imported.

Loans for Medical Students

The Ontario Medical Association has approved establishment of a bursary and loan fund of $25,000 for medical students. The fund is to be set up this year and apportioned to the four Ontario medical schools on a per capita basis, calculated on the number in the last four under-graduate years. Portions of the fund will be transferred as gifts in trust to the universities.

Root Cellars in Small Hospitals

It is important that perishable fruits and vegetables retain their original freshness and crispness, both to provide a more palatable product and to preserve nutritive value. Since harvested fruits and vegetables are living products composed largely of water, along with organic matter, they are subject to loss of moisture and tend to undergo rapid chemical change. Because refrigeration is limited in small hospitals due to lack of funds and space, a root cellar is ideal, especially during winter when fresh fruits and vegetables rise in cost.

The root cellar has proved to be one of the most practical types of storage for vegetables and fruits, especially on the prairies where low temperatures are common in winter months. Success of this type of storage will depend on proper location, construction and management. Good management involves control of sanitation, quality of the product stored, arrangement of bins, temperature, humidity and ventilation.

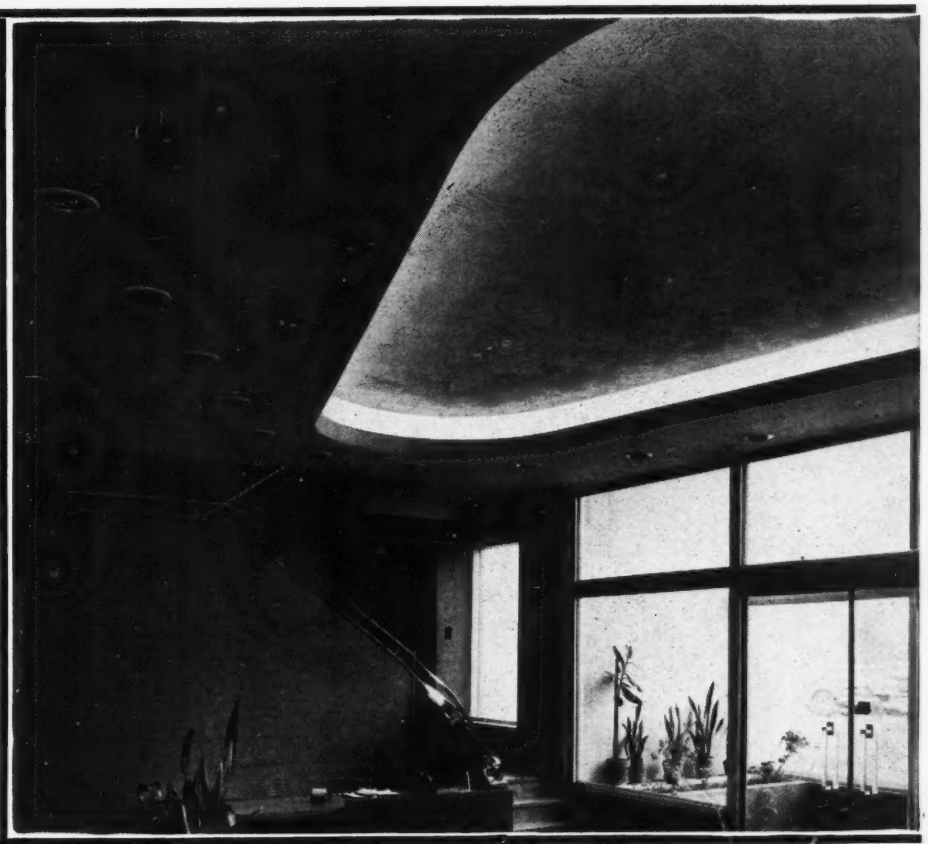
The south or west side of a hill is ideal for location. The slope prevents accumulation of water during run-off and ensures good drainage. Size depends on the demands of the hospital food service department. For the small hospital it is not advisable to have a floor area of less than 120 square feet. Excavation should be at least six feet deep, for the earth temperature at a depth of ten feet is almost constant at 38 degrees F. the year round. To prevent frosting of vegetables, good insulation is required in the walls, and the roof should be thick and well insulated.

Good vegetable storage does not in itself guarantee the best product but intelligent management along with such storage will achieve optimum results. A complete clean-up by disinfecting every year or oftener will insure against fungous or bacterial dis ease. Only sound products, free from disease and bruises should be stored. Care must be taken that products are used up according to how long they have been in storage. Good bin arrangement will allow fresh air to circulate around the vegetables. The best temperature for vegetables is between 35 and 40 degrees F. Humidity should be high but not so high that moisture accumulates on the walls. Ventilation if properly regulated will prevent condensation of moisture. Two vents are required, one for air intake preferably near the floor and another near the ceiling for air outlet. — *Regional Hospital Council News.*

What a Diet!

At the Johannesburg General Hospital, a newly arrived sister was startled to find that the treatment of a polio patient, known to his intimates as Moose, included whisky and soda and cigars when requested. The sister read further that the patient's diet was to consist of caviar and champagne. Suspecting that these instructions had been added by the patient, the sister turned to the doctor's case notes to compare the writing, only to find that these had been writen by the same hand. What the sister did not know was that Moose, before contracting polio from his patients, had been the doctor in charge of the ward and that, after being examined by a colleague, he had written his own case notes, diet and treatment. In spite of receiving the same treatment as all the other polio patients, Moose made a good recovery. He maintains, however, that if his treatment had been followed, his recovery would have been poshitively ashtounding.—*South African Nursing Journal.*

Quiet always makes a grand entrance!



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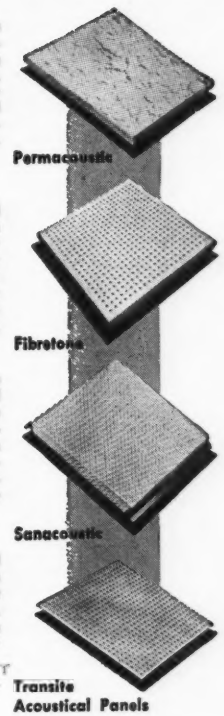

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The Dietitian in a Metabolic Unit For Children

The Hospital for Sick Children, Toronto, has expanded its facilities for research in metabolic disturbances in children. In February 1955, the Research Institute of the hospital opened a special unit consisting of a six-bed ward with its own staff of doctors, resident intern, nurses, dietitian, and laboratory technician. This "Metabolic Unit" provides facilities for the study in minute detail of abnormalities in body function. To date some of the conditions which have been investigated are coeliac syndrome, nephrosis, Vitamin D resistant rickets, growth retardation, hypertension, scurvy, hypophosphatasia, and renal diabetes insipidus.

The research physicians select the patients and determine the type of investigation. The nurses are especially trained in scientific techniques as well as paediatric nursing. The dietitian is responsible for all food, and the laboratory technician for all chemical analyses. Each person contributes a vital part of the whole project.

Investigation of a patient's ability to utilize certain nutrients is carried on by comparing intake with output. This is called a "balance study". With adult patients it is possible to explain the reasons for the study and the necessity of eating all the food served. It is much more of a problem to keep children on a constant diet. The dietitian discusses the child's food habits with the parents and explains the type of diet involved. An adjustment period is necessary before a balance study starts so that the child will become accustomed to hospital routine and his special diet. A study cannot be undertaken if the appetite is not normal, and so no child is admitted if he has a complicating acute condition. Every effort is made to keep him happy.

After a trial period of four or five days, depending on the child, it is possible to arrive at a diet constant in types of food and portion size. The diets are simple but calculated to give the required nutrients. Monotony of the menu is a major problem with the older children. The fewer types of food served, the less chance there is for error. An analysis of a weighed duplicate of one day's meals provides the composition of the food served. Any food rejected is carefully collected and analyzed. Thus the exact intake is known. The output is determnied by analysis of the urine and faeces.

All food used is chosen with care to ensure constant food values. Canned vegetables and fruit are from the same pack lot. Meat is prepared in advance of the study. Two types only are used —breast of chicken and lean minced beef. The chicken is obtained from the same source so that the breed and feed will be constant. The beef comes from the top part of the upper round of one carcass. It is then trimmed of all fat, minced and frozen in portions. Enough sliced white bread to last several months is obtained from one batch of bread from the bakery and is frozen. Butter and fluid milk are purchased from the same suppliers. Sometimes powdered milk and evaporated milk are used.

The cooking and serving of the food used is also very important. The canned vegetables are drained for

An article by Anna M. Fanset, dietitian, the Hospital for Sick Children, Toronto, Ont. Reprinted from "Canadian Nutrition Notes," May 1956.

fifteen minutes, then weighed directly into the individual casserole dishes in which they will be served. A vapour-proof paper is placed between the lid of the casserole and the food. This paper prevents moisture collecting in the dish during the steaming process. The vegetables are placed in the steamer thirty minutes ahead of the serving time. Fruits are drained and weighed directly into the serving dishes. Cooked breast of chicken is weighed, heated and served in the same manner as the vegetables. Minced beef is cooked in individual frying pans. The meat is weighed before and after cooking. A rubber scraper enables one to remove all the meat particles and gravy. The bread is weighed into servings as soon as it is taken from the freezer, then wrapped in transparent vapour-proof paper. The butter is weighed in portions. All bread is buttered before serving. The beverages, fruit juice and milk, are weighed into glasses and covered with wax paper.

It is possible to do a balance study on an infant. All ingredients for the formula are weighed, mixed throughly, and sterilized. Before feeding, the nurse weighs the buttle plus formula plus nipple, plus the bib, which will be used. After feeding they are weighed as before. The difference is the food intake.

Mealtime is a very important period for everyone in our metabolic unit. The nurses keep the children at quiet play for half an hour beforehand. Any laboratory tests must be done some time before the meal hour. A happy atmosphere does much to help the children.

Consultations about each case are held twice weekly with each member of the team entering into the discussion. The final results are reported at a seminar. From time to time the children return for check-up on their progress.

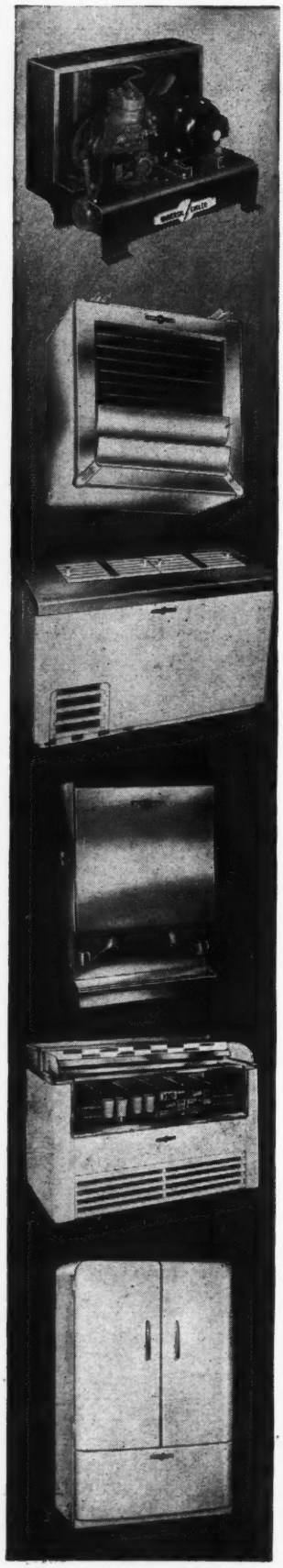
New Private Hospitals in B.C.

Newest of five private hospitals built during the past year in British Columbia is the 30-bed Lindross Private Hospital which has been licensed to care for medical, chronic and convalescent patients. Located in Burnaby municipality immediately east of Vancouver, the one-storey ranch-style building was designed by Jocelyn Davidson, architect. Read, Read, Jones and Cristofferson were consulting engineers, the hospital being built for lease by Botham Investments Ltd.

The hospital features an expansive patio accessible from four of the five four-bed wards and from the patients' lounge. There are four rooms for private patients and two separation rooms for special cases. All rooms and wards are equipped with wash basins, built-in vanities, closets and telephone jacks, and each bed has its own communications connection with the nurses' station. Superintendent Gladys Lindross, R.N., will reside in a three-room apartment which is part of the building.

Besides a fully-equipped kitchen, the hospital has a special room for the convenience of staff members and separate wet and dry utility rooms. Warm pastels predominate in the interior colour scheme while the cedar siding exterior is buff with dark stain trim.

According to Andrew Rose, inspector of hospitals for British Columbia Hospital Insurance Service, the Altamount in West Vancouver, Edith Cavell in Vancouver, Florence Nightingale at Whalley and Wayside House in Victoria have been specially built as private hospitals in the past year.



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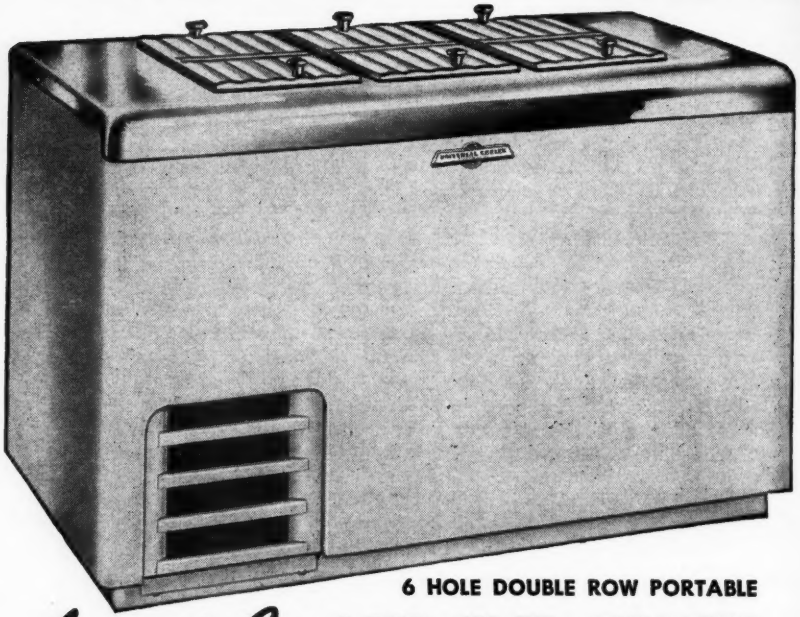

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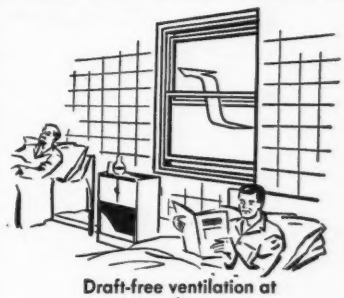

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On Brevity

The advice of Polonius in *Hamlet*: "Since brevity is the soul of wit, and tediousness the limbs and outward flourishes, I will be brief," indicates the importance of brevity in letter writing. Yet sheer economy of words alone does not constitute brevity; if a piece of writing tells the whole story, and only that, it is not too long. One writes not to impress, but to be understood — a process which demands mental effort. As Churchill said in a wartime memo: It is sheer laziness not compressing thought into a reasonable space. The active verb, the concrete noun used in short, graceful sentences will best convey the impression of simplicity. One cannot adorn simplicity. It is a mark of truth. The comparison between the 300 words in the United States Declaration of Independence, and a U.S.A. Order to reduce the price of cabbage 26,911 words in length, needs no comment. Finally, foresight in knowing one's audience, and what it is one wishes to tell them complete the severe discipline which the writer must impose upon himself.—*from The Royal Bank of Canada Monthly Letter.*

Measuring
The Hospital Food Dollar

A food cost survey on approximately 30 small hospitals in Saskatchewan was made in the fall of 1954 by the Division of Hospital Administration and Standards, Saskatchewan Department of Public Health. The purpose of this survey was to find the breakdown of the total amount of money spent on raw food by each hospital for six months, and the amount of food obtained for the expenditure. It was also to serve as confirmation that patients and staff could be fed nutritious diets for less than 75 cents per day, per person, which is the maximum raw food expenditure allowed each hospital under the Saskatchewan Hospital Services Plan.

The hospitals chosen for the survey were ones that had been operating within these costs for some period of time. Fairly accurate record-keeping was an essential requirement as well as completeness of invoices. The survey covered the first six months' operation of 1954. Ten of the best hospitals were chosen as examples which could be used as a guide by other hospitals. They ranged in size from 9 to 61 beds and were situated in various districts throughout the province.

A visit was paid to each hospital by the division dietitan and the accountant. Invoices for every month were reviewed and a chit, containing the quantity purchased, price and name of commodity, was made for each item. In Regina the chits were sorted into groups and totalled. Calculations of the cost of food per person, based on the selected six month period, were made. To check on the nutritional adequacy of the diet provided, the total number of meal days was divided into the total amount of food purchased. All 10 hospitals showed adequate amounts of food purchased. The last step of the survey was the calculation of the percentage of the food dollar spent on individual items and group items. The average results were 26.3% spent for meat products, 27.12% for dairy products, and 46.57% for general groceries. An average of 6½ oz. of meat and 2 glasses of milk were being provided per person per day. — *Canada's Health and Welfare*

A long face and a broad mind are rarely found under the same hat.

Northern Diet Improves

The diet of centuries is being altered in Canada's northern territories, where enterprising Indians are turning to agriculture to supplement the supply of fish, game, and trading post goods that have been their only food through generations of following the game trails.

In choosing to follow agriculture, a number of bands and individual Indians are assuring themselves of a good supply of food and also making profits through selling their surplus to the mining and industrial establishments that are entering the north. One of the newest projects is at Hay River, in the Northwest Territories. In 1955, this three-year-old venture produced 400 bags of potatoes on 11½ acres. Every participant received a bag of potatoes for each day of work. The surplus was sold.

Agriculture is not easy in this region, for the topsoil is thin, and the only land that can be cultivated is that which lies within two or three hundred feet from the river. The remainder of the soil remains frozen all year round. There are an average of 49 days free of killing frost, although rapid growth compensates somewhat for this.

Gardens have also been established at nearby Resolution and Rocher River, the Yukon, and the Fort Vermilion Agency in northern Alberta. In 1954, Indians of this agency produced 2,544 bushels of potatoes, turnips and a few carrots—more than two bushels of vegetables for every man, woman and child concerned. Most of the agency's 1,300 Indians hunt and trap over a wide area, but a number of these are also turning to cattle raising. By last March they had 240 head of cattle.

Indians throughout the James Bay Agency in Northern Ontario are showing a keen interest in gardening. In 1954, the Moose Fort Band broke 3 acres of land and planted potatoes, turnips, onions and carrots. Each family on the reserve maintained its own individual plot. The 1955 Crop provided vegetables for immediate consumption and enough for each family to store 15 and 20 bags of potatoes for use this winter.

The addition of fresh vegetables to the Indians' diet does much to cut down the incidence of sickness among Bands. — *The Indian News.*

Payment for Emergency Care

Many hospitals today confuse "emergency" with "indigency" when making out bills for emergency treatment. The first concern of the hospital must be the immediate treatment of the injured patient, but should it follow that those emergency patients who are financially able to pay for this care be billed only a nominal charge for the service? Prepayment insurance will usually cover the cost of emergency in-patient or out-patient care. Should the patient be unable to pay, the charges may be listed as a charity allowance entry to balance the books. —*Hospital Progress*

Lucky

First Camper: "I do all the cooking and baking for you fellows, and what do I get? Nothing!"

Second Camper: "You're lucky, we get indigestion."

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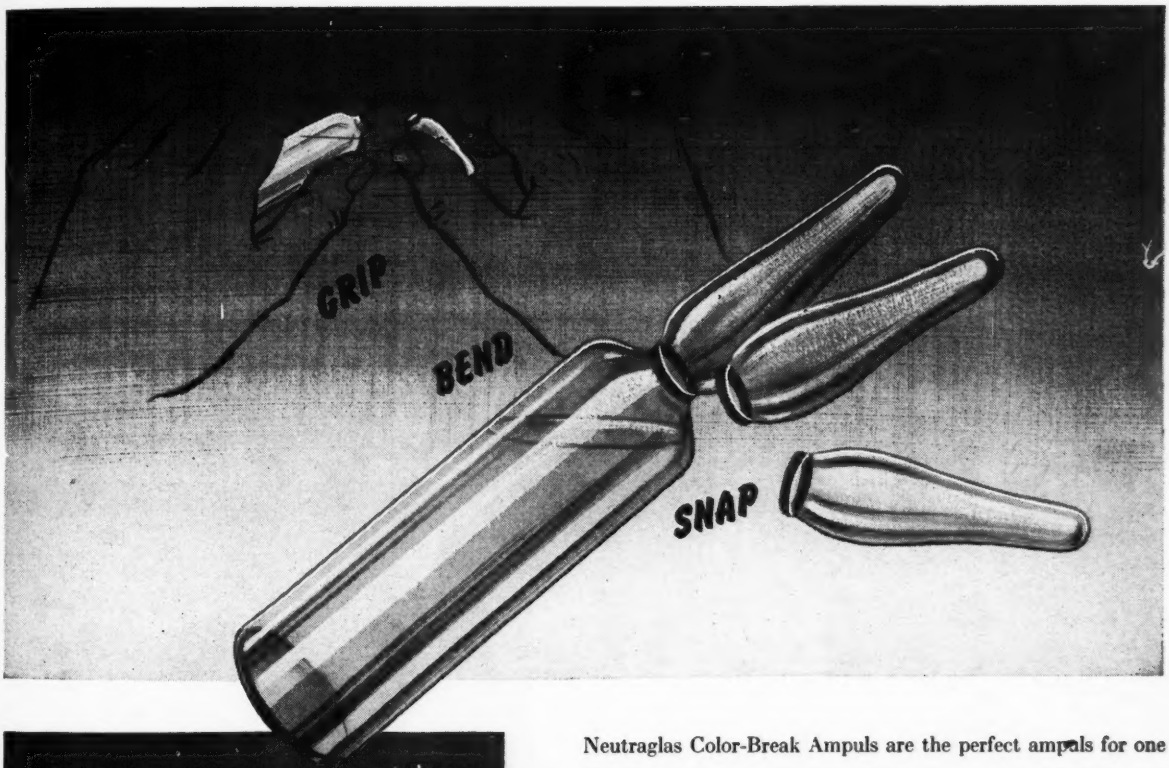

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Nutrition Services in Newfoundland

The nutrition program in Newfoundland is placing its emphasis on two aspects, nutrition education, and the provision of supplementary foods to vulnerable groups.

The nutrition education program is directed towards achieving the objectives outlined in 1947, namely: an increased consumption of milk among children; a more widespread use of skim milk; an increase in the intake of cod liver oil among children; a more widespread use of other types of fish besides cod; increased cultivation and use of more vegetables, especially the green leafy variety; improved methods of cooking vegetables to prevent destruction and loss of vitamin C; an increased consumption of fruit, especially locally grown fruit; an increase in the preservation of fruit and vegetables as a reserve for winter and spring.

Assistance was given to nurses regarding the nutrition program, educational materials and consultative services, and upon request in interpreting special diets to patients and families. Several hospitals were visited and advised on food preparation. Consultative service was given through individual visits, a weekly radio food and nutrition program called "Kitchen Corner", a bulletin, *Newfoundland Nutrition Notes, News,* and films as supplements to nutrition lectures.

Concentrated orange juice and cod liver oil are being distributed by the Department of Health to certain vulnerable groups. Concentrated orange juice, available to expectant mothers, and babies up to one year of age, is being distributed through cottage hospitals, medical health officers, nurses in districts and from some Red Cross branches. Because of isolation problems, it is difficult to place supplies within reach of all communities, and consequently all who could qualify do not benefit from this scheme. The total quantity of 832 gallons was distributed for the year ending 1955.

Cod liver oil is available free of charge to expectant mothers, infants, and children. This cod liver oil contains a greater concentration of vitamins than the ordinary cod liver oil. Teachers are asked to distribute the cod liver oil to those children who are willing to consume it. Its use is encouraged by nurses, teachers and other field workers, and by radio. —*Canadian Nutrition Notes*

Canadian Mental Health

(The 1955 Annual Report of the Canadian Mental Health Association contained a foreward "The Task is Tremendous", reproduced below.)

The menace of mental illness is still our major health threat in Canada. It cripples more human beings than all the major physical diseases combined. We return again with the same gloomy fact, perhaps even more strongly emphasized than before, that if the present incidence continues unchecked, one child out of every twelve born in Canada this year has the prospect of having to spend some part of its life in a mental hospital. The toll in lost human resources, mounting costs for adequate treatment, the loss of income during hospitalization with attendant welfare levies, added to the incalculable burden of actual human suffering and misery, presents such a drain on our nation's economic and human resources that mental illness demands the immediate attention of all thoughtful citizens.

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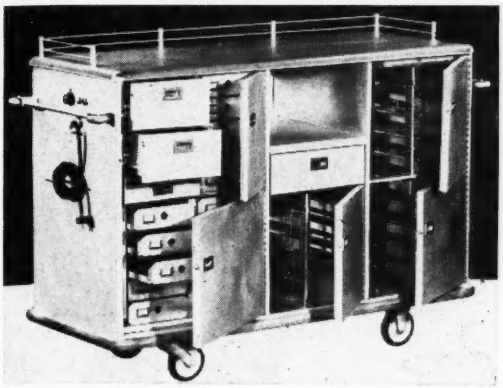

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C.N.A.

(Concluded from page 84)

to a consideration of common problems sometimes difficult and at times well-nigh impossible . . . due to differences in stages of development of nursing in those countries".

There followed a talk by Evelyn Pepper, Civil Defence Health Service, Ottawa, on "New Approaches to Civil Defence".

In the afternoon, Helen G. McArthur, director of nursing services for the Canadian Red Cross and recently returned from a post as nursing co-ordinator in Korea, presented an address "And the World Too". She stated that nurses have taken their humanitarianism beyond home, nation, language and political ideology to work on the international scene. "Canadian nurses are particularly fitted for this type of international contribution," she said. While in Korea, Miss McArthur was honoured when the new nurses' residence of the Seoul Red Cross Hospital was named after her.

Following the address "Are we Equal to our Future?" given by Byrne Hope Sanders, C.B.E., co-director, Canadian Institute of Public Opinion, an address was presented at the installation of officers by Trenna Hunter, the new president of the C.N.A. Miss Hunter stated that the search for "a better way" has been going on since the Association's foundation, and that progress will continue unhampered by, though always respectful towards, tradition and past achievement.

Trenna G. Hunter, R.N., B.A.Sc., new president of the Canadian Nurses' Association, graduated in 1939 from the Vancouver General Hospital School of Nursing. She graduated from the University of British Columbia's Public Health Nursing course, and completed the B.A.Sc., degree in nursing, taking courses at U.B.C., McGill and the University of Manitoba. In 1944, she was appointed to her present position as director of Public Health Nursing for Vancouver's Metropolitan Health Committee.

Other officers appointed are:

1st vice-pres: Alice Girard, director of nursing, Hôpital St. Luc, Montreal, P.Q.

Second vice-president: Helen Carpenter, assistant professor, University of Toronto School of Nursing, Toronto, Ont.

3rd vice-pres: Electa MacLennan, director of nursing, Dalhousie University, Halifax, N.S.

General secretary: M. Pearl Stiver, Ottawa, Ont.

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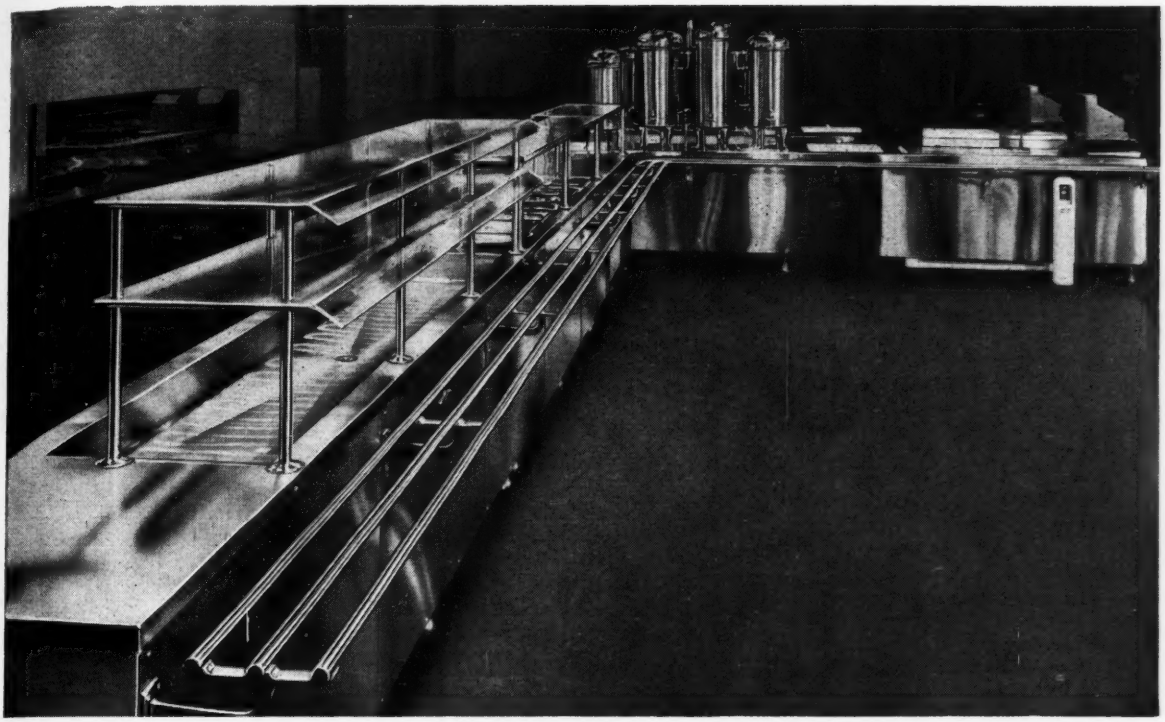

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Dept. H-3

Twenty Years Ago

("The Canadian Hospital", September, 1936)

Where patients are to remain in hospital for long periods, a member of the dietetic staff should not only be assigned to that particular case, but make frequent personal calls, when compatible with the comfort of the one visited, in order to learn, at first hand, any idiosyncracies about diet that may be present. If these do not clash with the advice of the physician, they should be respected and carried out cheerfully. Wherever possible a hospital should offer a la carte service to its private patients; or in any event, such variety to ensure something acceptable and pleasing for varied tastes. Scrupulous cleanliness and unfailing daintiness about everything pertaining to food, of course, is an essential needing no comment.

The British Columbia Cancer Foundation has recently received three and one-half grams of radium. Owing to a considerable reduction in the price of radium and a special arrangement, the entire amount was purchased for but $100,000. It is understood that a financial campaign will take place in the near future to raise additional funds for the extensive program of this foundation.

Considerable new construction is being undertaken or proposed in various parts of Canada. A new $100,000 addition to the mental hospital at Oliver, 10 miles from Edmonton, will be erected shortly. Plans for the Meek Memorial Laboratory, which has been proposed as an addition to the Victoria Hospital, London, and the medical school of the University, are taking shape and early construction would seem possible. The Sick Children's Hospital, Toronto, is adding two new operating rooms on the fifth floor. The new million dollar wing of the St. Jean de Dieu Hospital, Montreal, directed by the Sisters of Providence was blessed at an impressive service held recently. The Hôpital St. Laurent in Montreal is constructing a four-storey wing at a cost of $75,000. The small hospital at Bridgetown, Nova Scotia, is being replaced by a larger institution, made possible by the purchase of a larger residence.

It is anticipated that the Sisters of Martha will open a hospital in the near future at Grenfell, Saskatchewan.

The small Emergency Hospital at Terrace, B.C., was damaged by fire in July. Fortunately, the patients were evacuated without mishap, and the volunteer fire brigade was able to confine the fire to the roof.

With the arrival of the harvest season the majority of our hospitals will be busy endeavouring to gather in their many accounts which have been set aside for "fall collection." With agriculture playing such an important part in our daily existence it has been and always will be necessary for us to carry many accounts until the crop is harvested, but whether or not these anticipated returns are actually received depends a great deal upon the amount of crop available and the organization of the hospital's collection facilities. The former condition is not a controllable factor and all too often we are disappointed in the crop returns. This year appears to be no exception for Canada has been hadly hit with drought, but despite this there is no doubt that in the majority of areas there will be at least sufficient crop to enable at least a portion of the many bills to be paid. This, coupled with higher prices for wheat, should give us some encouragement.

I am a great believer in luck. I find that the harder I work the more I have of it. — *Stephen Leacock.*

People

(Concluded from page 28)

Oshawa Nursing Appointments

It has been announced at the Oshawa General Hospital that Gladys Hill, who has been assistant director of nursing service, will be appointed assistant director of nursing and nurse education to take the place of Miss Markle. Jessie Finlay has accordingly been appointed assistant director of nursing service.

• • • •

Jewish General Hospital, Montreal

The Jewish General Hospital, Montreal, P.Q., has announced the appointment of Frederick Goldstein as administrative assistant. Mr. Goldstein has been associated with the hospital for 20 years, and has served most recently as comptroller. G. M. Belkin has been appointed comptroller, having previously served as comptroller to the Federation of Jewish Community Services in Montreal.

• • • •

Appointment of New Administrators

The appointment of C. E. Dalziel as executive director and administrator of Queen Elizabeth Hospital of Montreal, P.Q., was announced recently. Mr. Dalziel has been a member of the hospital's board of management since 1936.

Mrs. Mona Bordon, R.N., has been appointed superintendent of the Red Cross South Cumberland Memorial Hospital, Parrsboro, N.S., in place of Mrs. Eileen Beaton, R.N.

A. E. Davidson has been appointed administrator of St. Andrew's Hospital, Midland, Ont., succeeding Miss A. E. Ingham.

J. S. Lockie, business manager of Riverview Hospital, Windsor, Ont., has been appointed superintendent in succession to Dr. John. M. Nettleton.

• • • •

Accountants and Business Managers

The following have been appointed at hospitals in Ontario:

Don Sherin as assistant accountant at St. Thomas-Elgin General Hospital, St. Thomas; Mrs. Sadie Bollert as accountant at the Englehart and District Hospital; Mrs. M. McQueen as accountant at Peel Memorial Hospital, Brampton; and Brian Burt as office manager at Trenton and District Memorial Hospital.

• Norman Dearlove who has been for some years with the Hospital Division, Ontario Department of Health, has left the government service to become administrator of the Cobourg General Hospital. Mr. Dearlove is a graduate in Hospital Administration, University of Toronto.

• Ray Krock, until recently business manager at Humber Memorial Hospital, Toronto, Ont., has gone to Iroquois Falls as hospital business supervisor with jurisdiction over three hospitals, Iroquois Falls, Smooth Rock Falls, and Pine Falls in Manitoba. He replaces H. J. Peddie. Succeeding Mr. Krock at Humber Memorial Hospital is G. A. Campbell.

• John Kunetsky who left Sioux Lookout to assume the duties of office manager at McKellar General Hospital, Fort William, Ont., replaces J. T. Walker who is now administrator at Atikokan General Hospital. Harold Nelson, formerly at Orangeville and Trenton, is replacing Mr. Kunetsky at Sioux Lookout.

• J. Boyd McAulay, for the past six years accountant at Toronto Western Hospital, Toronto, Ont., has been appointed treasurer succeeding M. B. Wallace who is now general superintendent.

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Cheese

(Continued from page 41)

cheddar cheese in Canada must be held for at least sixty days before it is sold.

But cheddar is only one of many kinds of cheese made in this country. Canadian processed cheese is known to all of us as a "just right" cheese for sandwiches, sauces, and in casseroles. This cheese, now taken for granted, is really a "baby" in the prolific cheese family, for it's only been with us since 1921. Prepared by grinding together selected cheddars, blending with milk solids and milk or water plus an emulsifying agent, then pasteurized and processed, this cheese is marketed in sliced and unsliced loaves and a variety of other packaging styles. The texture is smooth and there is no rind. The degree of sharpness varies with the cheese blended together but most of it is mild in flavour. Some of it comes as pimiento and garlic processed cheese; remember there's a wine-cured processed as well as cheddar. Not to be missed either are the many brands of processed cheese spreads now on the market . . . spreads that magically turn into a sauce at a moment's notice. There's cream cheese too, and it's available plain and in many flavour favourites . . . relish, pimiento, pineapple, chive, roka and smoked. Its smooth texture and consistency makes it tops for salads and appetizers. Recently, cream cheese has become an important ingredient in some recipes for cakes, fudge and frostings.

Canadian Limburger cheese, the centre of many jokes because of its strong odour, nevertheless has a delightful pungent flavour and with its creamy white interior, is beloved by its devotees. It is best served in sandwiches, with crackers and on cheese trays. Canadian Swiss cheese, with an appealing nut-like flavour, has distinctive "eyes" due to the action of the enzyme used in its manufacture. Swiss cheese on rye bread is as popular as peaches and cream.

Canadian blue-veined cheese is certainly a welcome addition on any cheese tray for it makes a fine ending to a pleasant meal. This semi-soft, white, blue-veined cheese has a salty and sharp flavour that blends well in salads, and dressings, with crackers and fruit.

And let's not forget Canadian Edam cheese, large and round so that it looks like a cannon ball, and colourful because it's coated with red wax. Edam is mild-flavoured and wonderful on the cheese tray. Canadian Gouda Cheese, looking like a baby Edam, is similarly red coated and its much smaller shape is that of a sphere, flattened top and bottom. Gouda's mild flavour makes it equally adaptable with crackers or fruit for dessert.

Canadian Oka cheese has a semi-soft, creamy texture and in flavour is between a cheddar and a Limburger. It is used for sandwiches, with crackers, as dessert and on cheese trays. On the other hand, Brick cheese is mild flavoured, is creamy yellow with a slightly open texture.

Canadian Camembert cheese, usually served in "portions" and in a semi-liquid state, is creamy in colour and texture and a real delight for the connoisseur. With such a recital of cheese we just couldn't overlook our old friend, cottage cheese, so excellent in salads, sandwiches, with fresh fruit for dessert and indeed in baked items too. Usually available as "creamed" cottage cheese, snowy white in colour, its

(Concluded on page 128)

Cheese

(Concluded from page 124)

flavour blends elegantly with a variety of foods.

Canadian cheese is not only easy to use and to cook with, it's a food that's easy to store too. All types of cheese should be kept covered in a cool place. It can be wrapped in heavy wax or parchment paper, in aluminum foil or kept in a covered container. To store a large wedge of Canadian cheddar, coat one side with wax . . . or press a piece of wax paper on to it with a hot iron. Then store the cheese, cut side down, on a plate or on wax paper, in a cool place. Small pieces of Canadian cheddar cheese can be grated and kept in a covered jar, ready to use in soups, sauces, and as a welcome garnish.

Of course, when we talk about Canadian cheese its food value certainly can't be overlooked. Because of its high protein content, cheese is an excellent alternate for meat, fish, poultry and eggs. Cheese has a good supply of minerals too, especially calcium and phosphorus, the bone and tooth builder and repairer. Cheese is rich in vitamins including A and the B complex, especially riboflavin. All these food elements are essential to good health. When we serve Canadian cheese at home or on the job, we're helping ourselves and those we serve to good health. When we help ourselves to Canadian cheese, we're helping ourselves to some mighty fine eating too.

Educational Activities at Moncton Hospital

A major function of Moncton Hospital, Moncton, N.B., is the training of hospital personnel. The best known phase of the teaching program is the three year course for student nurses leading to a certificate. However, the hospital provides a two year course in x-ray technology; accepts medical interns from Dalhousie University for experience in the Department of Paediatrics; co-operates with the Canadian Hospital Association by giving field work to students taking a two year correspondence course for Medical Records Librarians.

Moncton Hospital has been pleased to assist other hospitals by providing informal courses and training on request.

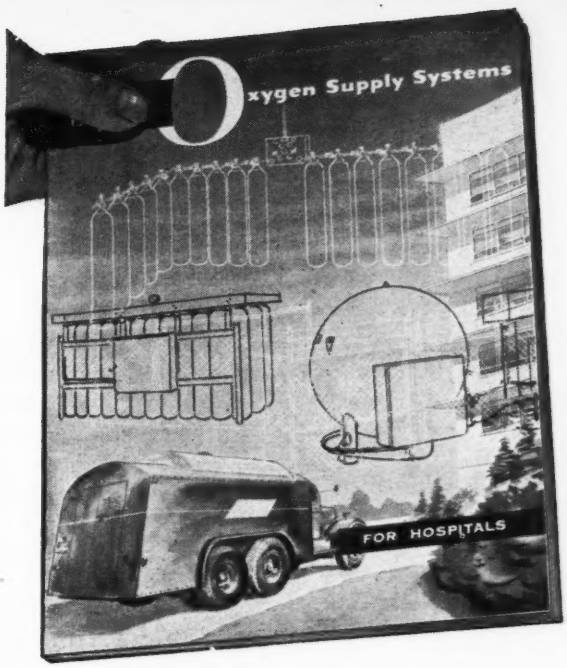
In order to give a high standard of training, the hospital must have propperly qualified instructors. Members of the staff are sent to other hospitals, or to universities, for advanced training and refresher courses. In addition to the instruction sponsored by the hospital, there have been several courses conducted at this institution by other agencies, particularly the New Brunswick Association of Registered Nurses. Moncton is a convenient meeting place, and the hospital is pleased to share its facilities in a co-operative effort to improve the standards of hospitals.

—Reprinted from the Moncton Hospital Annual Report, 1955.

Ontario Hospital Association—Pharmacists' Section

The meeting of the Pharmacists' Section at the Ontario Hospital Association's Convention is to be held October 23rd at the Royal York Hotel, Toronto, Ont.

Some of the topics to be discussed are: "The Legal Aspects of Hospital Pharmacy", "Purchasing and Stock Control", "Radioactive Isotopes", and "Personnel Patterns in Hospital Pharmacies". The installation of new officers will also take place at this meeting.



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Ontario Hospital Association Convention

The 32nd annual convention of the Ontario Hospital Association will be held in the Royal York Hotel, from October 22-24. Subjects of discussion for October 22 are "Hospitals and the Changing Scene", "Hospital Personnel", and "The Price of Prepaid Hospital Care".

Section meetings on October 23 will be held by Trustees', Nursing Administration, Accounting, Dietetic, Medical Record Librarians', Women's Hospital Auxiliaries', and Pharmacists' Sections. There will also be a Laundry Administrative Personnel Session. The election of officers and the appointment of auditors will take place at a general meeting.

The Ontario Hospital Services Com mission will be discussed by Arthur J. Swanson, the commission's chairman, and western views on health insurance plans will be presented "From the Viewpoint of the Hospital" and "From the Viewpoint of the Presently Functioning Service Plans".

On the final day of the Convention speakers' subjects will be "Disaster Strikes — You are There", "Medical Rehabilitation" and "Purchasing Standards". A report of the resolutions committee will be given, and final topics will be "Hospital By-Laws and Regulations" and "Changing Standards in Accreditation".

Mobile Fire-Fighting Unit

Thirteen separate and autonomous fire departments of Greater Toronto are to be co-ordinated into a mobile fire-fighting unit through a radio communications network sponsored by the Metropolitan Toronto Civil Defence Organization. With the assistance of a federal grant of $7,974 toward the $15,948 project, 13 portable receiver-transmitters and 13 portable auxiliary power units will be installed in fire department headquarters of the Toronto Metropolitan area. Provincial and metro governments will contribute equal shares of $3,987 to the project. Through this civil defence radio network municipal fire department headquarters will be linked on a common wave length with the City of Toronto headquarters and through that to the Metropolitan Civil Defence Headquarters at 280 Davenport Road. A signal sent through this co-ordinated network would immediately mobilize a fire-fighting column of 61 pumpers, 28 aerial or ladder trucks and 1,387 full-time fire fighters. In an attack, one of the first requisites for this equipment's survival is the dispersal of all available fire apparatus to the outskirts of the target area. Through these portable radio transmitter-receivers, the Civil Defence warning would be flashed to the 13 municipalities. In turn, the local fire headquarters would contact each of its pieces of equipment through existing, but stationary, communications channels and all would withdraw to pre-arranged locations. Additionally, the portable Civil Defence radio equipment could be used to co-ordinate, direct and integrate the fire pieces from these 13 municipalities when the re-entry was made to fight a fire battle after a bomb drop.

Over two million dollars worth of municipally-owned fire-fighting equipment will be controlled through this Metropolitan Toronto Civil Defence radio network embracing the municipalities and townships of Toronto, Leaside, Swansea, Weston, Forest Hill, Mimico, New Toronto, Long Branch, East York, Scarborough, York, North York, and Etobicoke.

Disaster Plan Required for Accreditation

A written plan for the reception and care of mass casualties is now a requirement of the Joint Commission of Accreditation of Hospitals. This plan should be well known to key medical and administrative personnel and, if possible, rehearsed several times a year. This requirement was added because it is common knowledge that hospitals which have been faced with the sudden need to care for large numbers of patients as the result of a bus accident, explosion, fire, or flood have been unprepared. Cognizant of this, medical and hospital groups have been studying the problem and, as a result, the American Hospital Association has published two handbooks, "Principles of Disaster Planning" and "Reading in Disaster Planning for Hospitals". The "Principles" is a step-by-step explanation of how to prepare the hospital to meet possible disaster with equipment and informed personnel. The "Readings" is a compilation of reports of how individual hospitals have handled community crises. If a hospital wishes help in developing plans, these guides may be of assistance. They can be procured from the American Hospital Association. The Commission does not have copies for distribution.

Angola

(Concluded from page 90)

rapidly as it usually does among people who have poor sanitation and poor nutrition.

Improvements in agriculture are resulting from the introduction of ploughs and oxen to replace part of the primitive hand labour. Fertilization of the soil and its conservation from erosion, the introduction of better types of animals, the more widespread cultivation and the use of fruits and vegetables, and, perhaps most important of all, the increase of knowledge through education are doing much to improve conditions. The influence of the white communities is a great incentive to better living on the part of the Africans.

While it is, unfortunately, still true that two thirds of the African people in Angola are hungry, or suffer from too poor a quality of food, badly balanced in their diets, there are indications that in the near future this number will be considerably reduced, and that many Africans will find their way to a better and more adequate nutrition.

No man can be wise on an empty stomach — *George Eliot.*

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Here is glassware that has the look and feel of luxury, yet costs less than other quality lines. Dominion heavy base tumblers are brilliant, crystal clear. At the same time, they are sturdy, easy to grip, less likely to tip or spill. What's more, their smart, simple design blends well with almost any scheme of decoration.

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331	8½ oz. Heavy Base	6	33
332	9½ oz. Heavy Base	6	39
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334	6½ oz. Heavy Base	6	34
335	9 oz. Heavy Base—Table	6	36
336	9 oz. Heavy Base—Tapered	6	40
337	8 oz. Heavy Base—Tapered	6	34
338	6¾ oz. Heavy Base—Tapered	6	34
339	5½ oz. Heavy Base	6	30

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A.H.A. Personal Membership Department for Hospital Engineers

The American Hospital Association's Personal Membership Department for Hospital Engineers was established May 1st, 1956, with approximately 250 engineers from member hospitals composing the "charter" membership group for the department. It is the first personal membership department of the A.H.A. and its purpose is to give persons with common interests the opportunity to share their experiences; and to supplement the activities of local engineering groups. Canadian members are the following:

Francis R. Benvenete, chief hosp. engr., St. Michael's Hospital, Toronto, Ont.; Leonard Corsie, chief engr., Sarnia General Hospital, Sarnia, Ont.; Harry J. Cunningham, asst. chief engr., St. Michael's Hospital, Toronto, Ont.; John H. Ford, chief engr., New Mount Sinai Hospital, Toronto, Ont.; A. K. Horn, chief engr., Children's Hospital of Winnipeg, Winnipeg, Man.; Lucien Lacoste, asst. gen. dir., Notre Dame Hospital, Montreal, P.Q.; E. V. Liversidge, maint. supt., Royal Columbian Hospital, New Westminster, B.C.; Thomas Porter, plant supt., Calgary General Hospital, Calgary, Alta.

Meetings of local hospital engineers associations offer the engineers an opportunity to discuss problems and listen to talks by leaders in the hospital engineering field. Several such groups of engineers have been organized and hold regular monthly meetings. ●

Coming Conventions

Oct. 1-5—International Congress on Medical Records, Shoreham Hotel, Washington, D.C.

Oct. 10-12—Convention, Canadian Association of Medical Record Librarians, Vancouver, B.C.

Oct. 16-18—Associated Hospitals of Alberta, Macdonald Hotel, Edmonton.

Oct. 22-23—Catholic Hospital Conference of Saskatchewan, Saskatoon.

Oct. 21-23—Women's Hospital Auxiliaries of Ontario, Royal York Hotel, Toronto, Ont.

Oct. 22-24—Ontario Hospital Association Convention, Royal York Hotel, Toronto, Ont.

Oct. 24-26—Saskatchewan Hospital Association Convention, Bessborough Hotel, Saskatoon, Sask.

Oct. 25-26—Ontario Conference of the Catholic Hospital Association, St. Joseph's Hospital, Toronto, Ont.

Oct. 27-29—Canadian Association of Occupational Therapy, Montreal.

Oct. 30-Nov. 1—Manitoba Hospital and Nursing Conference, Winnipeg, Man.

Nov. 1-2—A. H. A. Institute on Operating Problems of Small Hospitals, Winnipeg, Man.

Nov. 26-30—A.H.A. Workshop—Developing the Skill of Supervision, Montreal, Que.

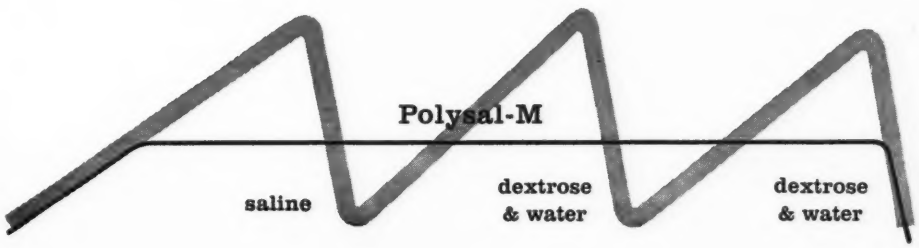
Dec. 3-6—A.H.A. Institute—Obstetrical Nursing Services Administration, Toronto, Ont.

Shorthand

Shorthand he wrote, his flowers in prime did fade and hasty death shorthand of him hath made. — *Epitaph in Westminster Abbey.* ●

"SAW-TOOTH" Effect Can Now Be Eliminated In I.V. Maintenance

Polysal®-M is a single maintenance solution that delivers a smooth uniform infusion free from sharp peaks (saw-tooth effect) caused by daily infusion of several different-type solutions. In medical, surgical, and pediatric patients, Polysal-M is used routinely where oral intake of food and water is restricted. Uniformity prevents over-loading, water intoxication and edema formation.



ADEQUACY

Optimum daily requirements of electrolytes, carbohydrates and water are met by the daily infusion of 3 liters of Polysal-M.

SAFETY WITH SIMPLICITY

Since the potassium content is limited to 16 mEq per liter, the standard rate of infusion is used. Contents in mEq per liter: Na_40, K_16, Ca_5, Mg_3, Cl_40, HCO_3_24. (Note that Cutter Polysal-M contains calcium.)

Contraindications: ANURIA and oliguria; HYPERPOTASSEMIA associated with chronic nephritis, untreated diabetic acidosis, severe burns, massive traumatic injury, and anuria.

Available with 2½%, 5%, or 10% dextrose.

Talbot, Crawford and Butler* have reemphasized the importance of homeostatic mechanisms of the body in fluid and electrolyte therapy. Their report shows that in the presence of adequate urine flow, the body is able to retain or excrete water and electrolytes in accordance with body needs.

*Talbot, N. B., Crawford, J. D., and Butler, A. M., "Homeostatic Limits to Safe Parenteral Therapy". New Engl. J. Med., 248, 1100 (1953)

Simplify for Safety with

SINCE CUTTER 1897 **Polysal-M**

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BERKELEY, CALIFORNIA

CUTTER LABORATORIES INTERNATIONAL
Calgary Branch, Union Building, Calgary, Alberta

B. C. PHARMACEUTICALS LTD.
933 W. Georgia Street, Vancouver, B. C.

EARL H. MAYNARD
270 Main Street So., Weston, Ontario

Second International Congress on Medical Records

The Second International Congress on Medical Records will be held in Washington, D.C., from October 1st, to 5th, 1956. Sponsoring associations are the American Association of Medical Record Librarians, the Association of Medical Record Officers of the United Kingdom, the Australian Federation of Medical Record Librarians and the Canadian Association of Medical Record Librarians. Other countries will be represented.

Two matters important to all will be discussed as study projects at this Congress: "Diagnostic Indexes and Classifications", and "Retention of Records". Canadian delegates are participating in these projects; and, in order that they may be aware of existing conditions throughout Canada and of the attitudes of the administrative staff of hospitals, questionnaires have been sent out to most hospitals. As time is very short an early reply is anticipated. There may be those whom we missed or who failed to receive their questionnaire and we accordingly include the questionnaire in this issue of *Canadian Hospital* hoping for comments and suggestions.

International Study Project I—Diagnostic Indexes and Classifications

(Canadian representative: Margaret Glynn, Queensway General Hospital, Toronto, Ont.)

1. Do you have a diagnostic index?
2. Do you use Standard Nomenclature of Diseases and Operations?

Do you use the International Statistical Classification?

Do you use another nomenclature (please specify)?

3. How are diseases and operations indexed (e.g. indexing, cross indexing)?
4. Are you considering changing your system in any way?
5. Do you feel that these indexes are used by your medical staff sufficiently to warrant the time and knowledge required for their compilation?
6. A frequent complaint is: "Our doctors do not use terminology suitable for such a nomenclature as Standard Nomenclature of Diseases and Operations". Have you any comments?

International Study Project II—Retention of Records

(Canadian representative: to be announced)

1. How long are medical records kept in your hospital?
2. How long do you feel they should be kept?
3. Are records older than ten years used for other than personal information such as age, et cetera?
4. What system for numbering and filing medical records is used in your hospital? (i.e. centralized, decentralized-serial, unit, or serial-unit)
5. Are nurses' notes kept separate from the medical records? If so, how long are they retained?
6. Are medical records bound for storage purposes?
7. Are your medical records microfilmed?
8. Do you have any suggestions regarding retention of records which might be practical on an international basis?

It is hoped that a report on the findings and any conclusions reached by the study projects will be available at a later date. — *Mrs. Ruth Melby, R.R.L.*

Trusteeship as a social honour or merely as the reward to a public-spirited donor is no longer tenable. Knowingly or unwittingly, today's governing board member holds in trust the future of our voluntary hospital system. —*George Bugbee*

Provincial Notes

(Continued from page 86)

McLaughlin (Herbert Morse Union Hospital), J. LeBastard (Eastend Union Hospital), and N. A. Hall, (Shaunavon Union Hospital).

WEYBURN. Extensive alterations and additions to an estimated cost of $250,000 are planned for the Saskatchewan hospital here. Architects are Izumi, Arnott, and Sugiyama.

Alberta

BEAVERLODGE. Work has been completed on the new $175,000 one-storey, 20-bed Beaverlodge Municipal Hospital. The old hospital building, erected 20 years ago, will be converted to a nurses' residence.

LETHBRIDGE. Rehabilitation equipment valued at $9,129 will be purchased by the Lethbridge Municipal Hospital through a national health grant. The equipment, an exercise table, hydro-therapy treatment tank and a diathermy unit, is required at the hospital in connection with its rehabilitation program.

LETHBRIDGE. The Galt Rehabilitation Centre, converted from the 65-year-old Galt hospital, has been officially opened. The centre will accommodate seventy patients, suffering from chronic and long-term illnesses. The hospital has been completely renovated, the inside walls and furniture being painted in matching pastel shades. What was once a large ward on the ground floor is now a sunny, completely furnished lounge and dining room for those patients who can be up for a part of the day.

TOFIELD. An expenditure of $100,000 on a 12-bed extension to the Tofield Municipal Hospital has been approved by ratepayers. Plans include the erection of an addition from the present north wing, with a larger operating room, case room, laboratory and better facilities for out-patients. Construction will start this summer.

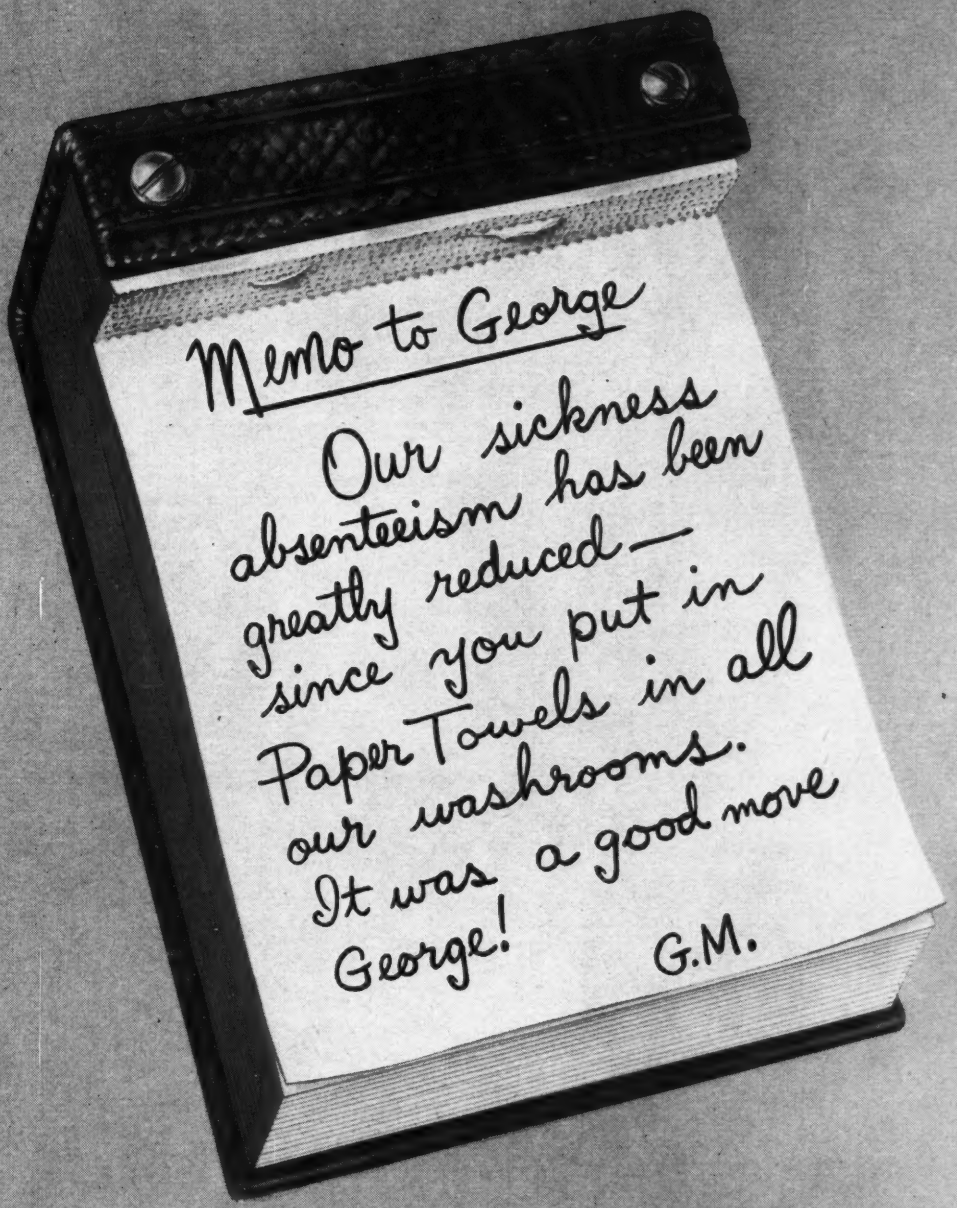
British Columbia

HANEY. Tenders have been called for the construction of Maple Ridge Hospital. Planned is a three storey cement building with accommodation for 60 beds, the facilities allowing for expansion to 100 beds.

KAMLOOPS. A program to renovate and provide additional bed accommodation to Royal Inland Hospital is being planned by architects McCarter, Nairne and Partners, Vancouver. The proposed addition will increase hospital accommodation to about 276 beds, nearly 100 more than present facilities provide. A new nurses' home and training centre are included in the plans. Most of the new facilities will be housed in a new wing which will also contain a surgical suite, maternity wards and kitchens.

NEW WESTMINSTER. Shortage of registered nurses forced the Royal Columbian Hospital to close one of its wards for the summer months. Hospital occupancy was straining facilities to the maximum. The closure cut 32 beds from the 430-bed capacity.

MURRAYVILLE. A new $18,000 administration wing has been opened at the Langley Memorial Hospital, also providing accommodation for two additional beds, raising the total number of beds to 51.



You will find paper towels in most hospitals . . .
schools . . . offices . . . industries . . .
wherever there are good washroom facilities.

You're safe—and you know it —everytime you reach for a paper towel

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Classified Advertising

Superintendent Wanted

Applications will be accepted for the position of Superintendent of the Yorkton General Hospital, duties to commence October 1 or as soon thereafter as possible. Applicants please state salary expected, experience and other pertinent data such as age, religious affiliations, etc. Address Col. F. Steel, Chairman of the Board of Governors, Yorkton General Hospital, Yorkton, Sask.

Assistant Superintendent, Medical, Required

University of Alberta Hospital, Edmonton, Alberta, Canada requires Assistant Superintendent, Medical. Starting salary $7,800 per annum. Annual increments of $500 to $9,800. Give full particulars, name, references and enclose photograph first letter, to A. C. McGugan, M.D., Superintendent, University of Alberta Hospital, Edmonton, Alberta, Canada.

Position Wanted

Young man requires position as Assistant Administrator or Business Manager. Qualifications include Professional Accounting Degree, also graduate in C.H.A. extension course in Hospital Organization and Management. Apply Box 903M, The Canadian Hospital, 57 Bloor St. W., Toronto.

Dietitians Required

Qualified Dietitians for 445 bed hospital. Large Student School. New and modern Dietary Department, cafeteria and trayveyor service. Salary commensurate with qualifications and experience. Day shifts only. Liberal holidays, sick leave, pension plan and other perquisites. Excellent working conditions and quarters prevail. Transportation refundable after six months. Apply Director of Dietetics, McKellar General Hospital, Fort William, Ontario.

Dietitian Wanted

For 200 bed Hospital. Please apply to Sister Superior, General Hospital, Sault Ste. Marie, Ont.

Assistant Dietitian

For Moncton Hospital, Moncton, N.B. (210 beds). Five dietitians on staff. Straight 8-hour day. Please apply to Chief Dietitian.

Dietitian Wanted
B.C. Civil Service
Tranquille T.B. Sanatorium
Near Kamloops, B.C.

Salary: $250. rising to $305. per month. To assist Chief Dietitian particularly with respect to therapeutic diets. Uniforms provided. Residence, meals and personal laundry nominal cost. Must be British Subject, graduate of recognized university. Apply Chairman, B.C. Civil Service Commission, Parliament Buildings, 544 Michigan Street, Victoria.

Medical Records Librarian Wanted

To take charge of department in new hospital of 245 beds. Excellent salaries and personnel policies. Appy—The Administrator, Sudbury Memorial Hospital, Regent Street South, Sudbury, Ont.

Medical Records Librarian

Registered Librarian to take complete charge of Medical Records Department of 445 bed accredited hospital. Well organized and staffed. Dictaphone service. Salary commensurate with experience. Excellent working conditions. Transportation refundable after six months. Apply R. V. Johnston, Superintendent, McKellar General Hospital, Fort William, Ont.

Administrative Personnel Placement Service

Mary A. Johnson Associates welcomes inquiries from Hospital Trustees and Administrators for assistance in locating Administrative and Department Head Level Personnel for Hospital and Medical Group positions.

Dr. Johnson is trained and experienced in Hospital Administration as well as Personnel Management and is available for Consultation of Personnel needs.

Our files contain many well qualified personnel as well as interesting openings.

We pride ourselves on careful screening of all our clients and thorough investigation of openings. Our aim: to match the applicant and the specific position.

MARY A. JOHNSON ASSOCIATES

11 West 42 Street, New York 36, N.Y.
Mary A. Johnson, Ph.D., Director

MEDICAL RECORD LIBRARIAN WANTED

Registered Librarian required to take charge of Department in 250 bed general hospital, with 100 bed addition opening this Fall.
The hospital is situated overlooking the beautiful Bay of Quinte. Good salary and personnel policies.

Apply to:

The Administrator,
The Belleville General Hospital,
Belleville, Ontario.

Check List for Administrators

Are you aware that:

1. Cross infection with staphylococcus aureus is a serious problem and that an article on this topic by H. O. Dillenberg, M.D., bacteriologist of the Department of Public Health, Regina, Sask., was published in the July, 1956, issue of *The Canadian Hospital*. Another article on the same topic was published in the July-August, 1956, issue of the *Canadian Services Medical Journal*.

2. A requirement for accreditation is a disaster plan for your hospital.

3. The research division of the Department of National Health and Welfare, Ottawa, has published several bulletins relating to various phases of hospital activity.

4. The Canadian Medical Association has revised the standards regarding the approval of hospitals for intern training and has recently published this information in booklet form.

5. The Ontario Hospital Association has published a very helpful booklet on press relations entitled *Two Sides to Every Story*.

6. The 1956 *Canadian Hospital Directory* contains a section of nine pages outlining various educational programs for hospital personnel.

7. The administration of too high a concentration of oxygen to premature infants while in incubators can cause a form of blindness known as retrolental fibroplasia and that several articles, about it have appeared in the literature of recent years.

May Run on Ions

An electronically run National Medical Library is a distinct possibility in the near future, Dr. Charles W. Shilling, deputy director of the Atomic Energy Commission's Division of Biology and Medicine, reported in Los Angeles.

"This would be a library of enormous capacity," Dr. Shilling told the Medical Library Association Convention, "with all medical and biologically related material coded so that wanted information could be electronically selected and dispatched to inquirers within a minute or so".

By combining an electronically operated business machine and a TV scanner, he explained, it would be possible to locate an article of, say, 34 pages, and transmit its contents verbatim to a receiver located in a distant hospital in no more than 60 seconds. —*World Wide Medical News*

Plans for Journal in Hospital Administration

A quarterly journal is being planned by the American College of Hospital Administrators, to be sent to college members free of charge while at the same time being available to the hospital field on a subscription basis.

The primary aim of the journal will be to provide ready access to literature in the field of hospital administration and to encourage publication of research and original thinking and practice in this field. The journal is intended as a non-competitive, scholarly publication, non-editorial in nature.

The subject matter will be limited to management topics of interest to hospital administrators and to hospital subjects treated from an administrative point of view. Subject matter will include theory and practice of hospital administration as it relates to organization, function, development, and management of the hospital; the hospital as a community institution; and the social integration of the hospital. Major articles will represent original writings or research by persons in the hospital or related fields in administration. — *ACHA News.*

There is more to life than increasing its speed. — *Gandhi*

News Released by Hospital Supply Houses

By C.A.E.

Johnson & Johnson Appointments

F. J. Round

J. M. D'Astous

Mr. F. J. Round has been appointed Ethicon suture consultant for Johnson & Johnson Limited. Mr. Round has had considerable experience in the field, and will be contacting English-speaking doctors and hospitals in Montreal and the Maritime provinces.

Mr. J. M. d'Astous has been appointed Ethicon suture consultant to cover French-spepaking doctors in Montreal and Quebec Province.

Sample Book of Vinyl-Coated Fabrics

The most complete sample book of vinyl-coated fabrics ever offered has just been released by Monsanto Oakville Limited. It has been designed to assist prospective users in evaluating the limitless possibilities of this type of material. Anyone concerned with upholstering, wall covering or decoration will find this book very useful.

It contains one-hundred and seventeen actual samples of vinyl-coated fabrics in a wide range of embossings grouped in such a way as to show the typical colour ranges available in each. Over half the samples illustrate the new Monsanto 3D- deep-textured patterns that are gaining such wide acceptance in the wall covering field, also combination installation because of their durability and beauty. The four original patterns of "Bamboo", "Straw", "Nubbe" and "Palmetto" have been increased to five by the addition of "Alphine", a strikingly new effect that features small delicate but distinctive vertical lines.

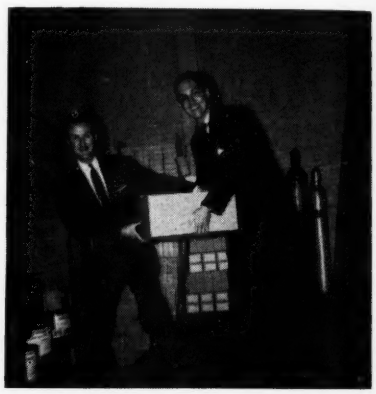
All vinyl-coated fabrics illustrated resist scuffing, cracking, peeling and fading. Unaffected by dirt or grease and easily cleaned with mild soap and water, it is easy to see why they are so suitable for appplications where hard wear or abrasion is a problem.

These new Monsanto sample books which are complete with price schedules and yardage specifications are available upon request from Monsanto Oakville Limited, Oakville, Ont.

Davis & Geck Establish Canadian Division

Faster and more efficient service for hospitals and dealers is behind the recent establishment of the Davis & Geck Division of North American Cyanamid, Limited. Sufficient quantities of standard D & G products are now maintained in the Montreal warehouse to insure adequate stocks for dealers and to step up delivery to hospitals. Distribution of D & G surgical sutures and other products in Canada is being handled by: Davis & Geck Division, North American Cyanamid, Limited, 5550 Royalmount Avenue, P.O. Box 1039, Town of Mount Royal, Montreal 16, Que.

All orders and inquiries should be directed to this Canadian address. A marked increase in the speed of filling and delivering orders is expected as a result of this change.



Pictured above happily expediting one of the first Davis & Geck shipments from the new Montreal warehouse are J. C. Halliwell (left), warehouse manager and J. C. Stuart (right), D & G Canadian sales manager.

Smith & Nephew Centenary

This year marks the centenary of Smith & Nephew Limited, manufacturers of Elastoplast and Gypsona prpoducts.

This famous concern was founded when Thomas James Smith opened a small chemist shop in Hull, England. Since then the business has grown to world-wide proportions. Today, the Smith & Nephew group employs 5,000 persons and incorporates more than fifteen separate companies.

In Canada, a subsidiary company which is a selling and distributive organization was formed in 1921 and handles the Elastoplast products, Nivea Creme, Gypsona plaster of Paris bandages and Slabs and Surgical Dressings.

In the United Kingdom, the Smith

(*Continued on page 146*)

Across the Desk

(*Continued from page 144*)

& Nephew group weaves its own material for use by manufacturing companies, and other companies specialize in research, development of a technical nature and marketing. Its range of products marketed in England extends to light clothing, sanitary towels, pharmaceuticals and hypodermic equipment.

Adams Illuminator Cool in Operation

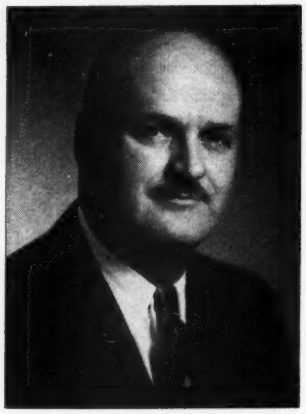
The Adams E & G Microscope Illuminator is designed to furnish a high intensity point source of illumination for microscopy, macrophotography and microphotography. A built-in transformer reduces operating voltage to 6 volts, resulting in cooperation and long bulb life. The high intensity illumination is supplied by a 6 volt, 2.75 ampere heavy coil filament bulb; operating current is 110 volt AC, 50-60 cycle.

The Illuminator can be focused from 6 inches to infinity and has a built-in iris diaphragm to control the size of the light spot. An aspheric condenser focuses the beam. The bulb housing may be set to any height between 1⅝ ins. and 10⅝ ins. at any angle by means of two thumb screws. Total weight of the Illuminator is 4½ pounds, most of which is concentrated in the base, making for great stability. The on-off switch is mounted in the base. A blue filter is provided for use when the Illuminator is used in microscopy.

Further information may be obtained from Clay-Adams Inc., 141 East 25th St., New York.

G. A. Hardie Sales Appointments

R. J. McCauley, Vice President and General Manager of G. A. Hardie & Co. Limited has announced the appointment of Gordon Middleton as sales manager and George Batten as sales supervisor. Both these men have been with the Company for many years.



Gordon Middleton

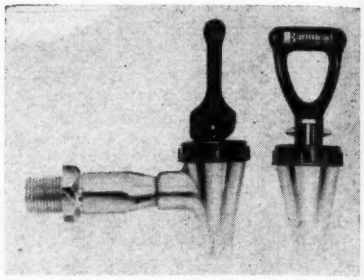
George Batten

Mr. Middleton will work from the Head Office in Toronto and Mr. Batten will be located in Burlington and will continue to supply his customers in the Hamilton district with Super-Weave textiles.

New Tin-Lined Faucet For Distilled Water

Barnstead Still & Demineralizer Company announces a new type of tin-lined faucet for distilled water distribution systems in laboratories and hospitals. The manufacturer claims it will give long, trouble-free service with complete purity protection. Barnstead specifications show that the faucet is both self-closing type and non self-closing type depending on which way the handle is thrown. This feature eliminates the problem of leakage, binding, dripping and regrinding, which are encountered with distilled water taps that rely on ground joints for tightness.

The faucet is constructed of tin-lined brass with silicon plug and plastic handle. The tin lining is approximately 1/16 in. thick and is permanently bonded to the metal. Connects to piping by ⅜ in. male thread which makes tin-to-tin contact with any Barnstead ⅜ in. fitting. Accessory fittings for mounting the faucet on wall are available.



Additional information may be obtained by writing the manufacturer, Barnstead Still & Demineralizer Company, 171 Lanesville Terrace, Boston 31, Mass.

Ohio "Diamond" Flush Service Outlet

A new "Diamond" flush service outlet for use with oxygen, nitrous oxide, vacuum, and compressed air piping systems has been recently introduced by the Ohio Chemical & Surgical Equipment Co. (A Division of Air Reduction Company, Inc.), Madison 10, Wisconsin.

Completely flush mounted, the mar-resistant stainless steel outlet presents a neat, smooth, and compact appearance. Separate and distinct motions are utilized to insert and release the adapter. Only one hand is needed to conveniently insert the adapter using a straight ahead push motion. The adapter is released with a slight twisting of the knurled ring.

Metering and other devices remain in a vertical position during insertion and removal. Maximum stability for attached administering apparatus is achieved with a non-swivel device not associated with the check unit. After installation, the unit is easily adjusted to compensate for plaster variations.

The "Diamond" outlet includes a self-sealing dust plug, and adequate spacing on multiple service outlets prevents interference between different types of administering apparatus. When necessary, the outlet can be quickly disassembled without the use of any special tools. The inlet filter screen is easily accessible.

Interchange of services is prevented through use of a simple, positive keying arrangement. A color-coded stainless nameplate is permanently attached to the check unit, eliminating mislabeling from interchange of cover plates.

Request Ohio Chemical's "Diamond" flush outlet bulletin for complete information.

Manual on "How To Sweep and Mop Floors"

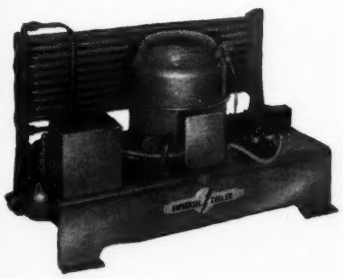
The authoritative "Manual on Sweeping and Mopping Floors," in a revised edition, is now available from Huntington Laboratories. This 24-page, 8½ x 11 inch booklet is based on careful job analysis and extensive scientific research that will help maintenance people save time in sweeping and mopping. It will improve the quality of their work and eliminate much wasted effort.

Primarily it's a picture book with complete instructions that not only tell bu show your men the best and quickest way to sweep and mop all types of floors. It gives proved methods that will streamline the work, no matter what type of building, room, stairs, or corridor is involved. The manual tells what type of brush and mop to use, and how to handle it for peak efficiency. It shows: How to use dust mops; How to sweep corridors and stairs without lost effort; Best method for sweeping large open areas; How to use a floor brush effectively; Illustrated sweeping and mopping techniques.

It is free, on request. Write for "How to Sweep and Mop Floors" to Huntington Laboratories Limited, 86 Parliament Street, Toronto 2, Ont.

Universal Cooler Introduces Water-Cooled Condensing Units

Illustrated above is one of a series of water-cooled hermetically-sealed refrigeration condensing units just introduced by Universal Cooler Company Limited, Brantford. They are available in 60 cycle, ⅓ to 3 h.p.



They are lower-priced than conventional, open type condensing units and they have no belt, shaft seal or motor brushes to require servicing.

No Hurry

Meek voice over the telephone: "Doctor, this is Mr. Henpeck. My wife just dislocated her jaw. If you're out this way next week or the week after, you might drop in and see her."

Index of Advertisers

SEPTEMBER, 1956

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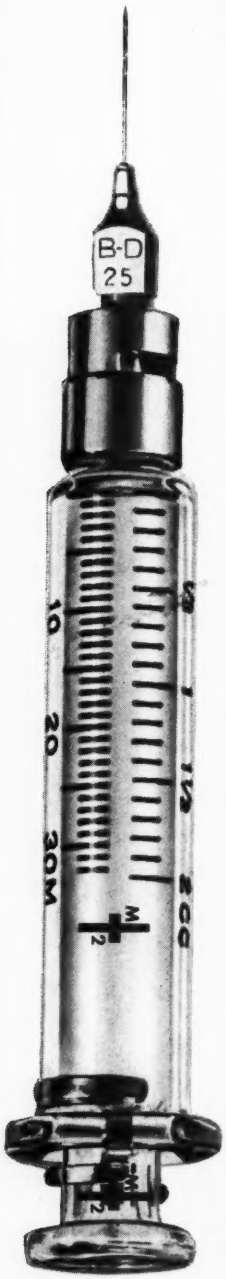
maximum
hypodermic
service



B-D

B-D MULTIFIT® SYRINGES

Increased assembly speed
every plunger fits every barrel.

Less breakage
unground barrels are tougher, stronger, more resistant.

Fewer replacements
in case of breakage, unbroken part remains serviceable.

B-D YALE® NEEDLES

Sharp points
for easier penetration of tissue.

Side beveling
inhibits seepage and afterpain.

Rustless throughout
made of Hyperchrome®
stainless steel.

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